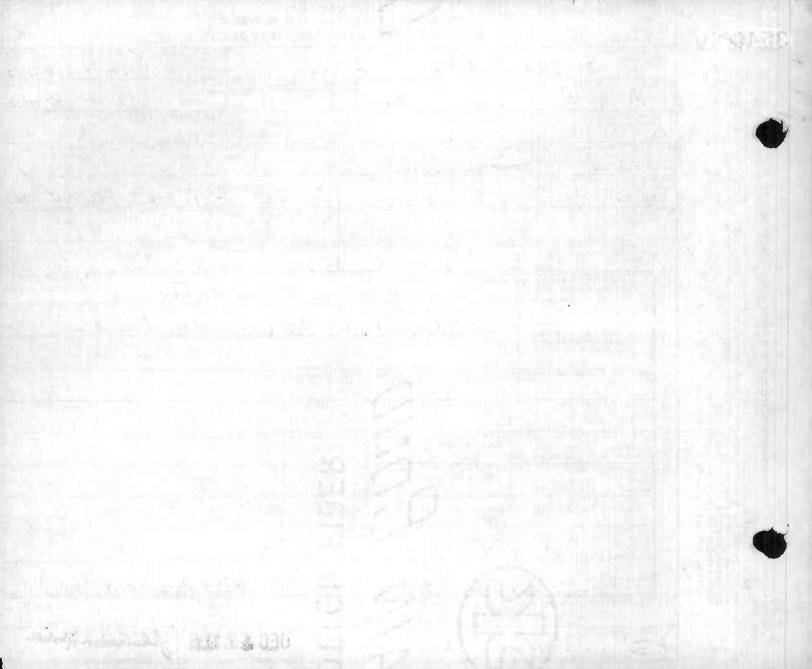
357698	11-	FOR STATE REGISTRAR	STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO.							3)
	I. DE	CEASED NAME FIRST EORPRINT) Bento	emin k	His	Aike	?u	2a. DATE KNO	WN MONTH	DAY YEAR - 4 19 25	26. HOUR
IN ICESSARY, PLEASE FILINERAL DIRECTOR. E.S. OR YOUR FILES. ID WITHIN 72 HOURS	3. SEX	M A RACE	5 DATE OF BIRTH	1899 86	DAY) MONTHS	1 YR. IF UNDER 2	24 HRS. 2c. DATE MIN. PRONOUNCED DEAD	MONTH 12	4 1985	2d. HOUR
PRESENT Y WITHIN	No:	RTHPLACE (STATE OR REIGN COUNTRY) rth Carolina	J	JSA	WIDOWED		D Alleo	any		MD.
AL PARTIE OF COMMENT OF THE PARTIES	Cui	TY OR TOWN OF DEATH	Memorial	OSPITAL, NURSING HOM FACILITY, GIVE STREET ADDRESS) Hospital		NSTITUTION	120. USUAL OCCUPAR FOR MOST OF WORKING School Tea	ON MYPE OF WORK LIFE)	OR INDUSTR	
AND SETAIN PECOLE	13g. S Ma:	ryland Gar:	NTY	130. CITY OR TOWN Accident	13d_ YE	INSIDE CITY LIMITS?	13e STREET ADDRESS	30× 18 /	121520 f	Md.
MA HH		Rufus	XXX Juds			MOTHER'S MAIDER Nora	MIDDLE	-	LAST Heste	r
RS AFTER DEA I. GIVE PAGES WITH FORM P I. PAGES I AN	160 V	Yes T	W IX	219-36-83		NFORMANT S. Hildes		Route Accide	1, Box 1	
EXECUTE WHITH 24 HOURS IN FERTION ST. EXECUTE WHITH 24 HOURS IN FEMALE REMAINS A BURRAL TERMINE PROMISH A RUNG WEBYEL HYGIENE. EMATION OR REMOVAL.	z	18. CAUSE OF DEATH (Enter- PART I DEATH WAS CAUS IMMED Canditions, if ony, whis gove rise to immedia cause (a) starting the unds lying cause last. FART 2 OTHER SIGNIFICANT CONDITIO	ATE CAUSE (o) DUE TO, O te (b) DUE TO, O (c)	Massul RAS A CONSEQUENCE RAS A CONSEQUENCE	lesotic OF	Casclic Condition GIVEN IN PAR	Infaction ovarcular	u diesa	BETWEEN ONSET	AND DEATH
VITAL RECONSTRUCTION ORD "PENDIO BE TO SHE WERE USED AS AT TO FEMAL CREATER OUR AND URLALL CREATER OF THE WEARL CR	CERTIFICATION	19a. DATE OF OPERATION	196 COND	ITION FOR WHICH OPE	RATION WAS P	ERFORMED?			20 AUTOPSY?	NO
NIVISION OF VITALI CERTIFICATE SHOUL SITING THE WORD "F EDED TO THE CHIEF E 3 SHOULD BE USED E DEPARTMENT OF H INTERIOR TO BURALI INTERIOR TO BURALI		210. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE O		M. MONTH DAY YEA	aR 21c HOW I	NJURY OCCURRED	ENTER NATURE OF INJURY I	N ITEM 18 PART 1 OR F		NO B
DIVISION THIS CERT E. WRITING WARDED PRAGE 3 STATE DEPARTS TO THE PRAGE 3	MEDICAL	214 INJURY OCCURRED WHILE NOT WHILE AT WORK AT WORK		OF INJURY (AT HOME, CTORY, FARM, ETC.)	21f. LOCATI STREET		CITY OR TOWN	c	OUNTY	STATÉ
EDICAL EXAMINER: THE HE CERTIFICATE A SHOULD BE FOR NERAL DIRECTOR: NERAL WITH THE S MORE, MARYLAND.		22a Certify that I took cho death resulted from: Na ACTUAL SIGNATURE YOUR EXAMINER'S NAME	rge of the remains de tural couses D. MUNCO		Autopsy [vicide , T M.DADD	Inspection Homicide ITILE (SPECIFY) Definity PESS 900	Undetermined monne MEDICAL EXAMINE Setou DY	DATE		ud.
TO EXECUTE BATTER BATTE	23a.B	urial, cremation, removal pecify) Burial	23b DATE 12/7/85	23c. NAME OF CE			23d LOCATION CITY OR TOWN Accident.	Garre	UNTY ST	21502
DHMH - 17 (VR A15 ME (5)) 20M 4/82	24.5	INERAL DIRECTOR PARE	man Gi	antsville,		6 DEC	A L SE	guia Day	SIGNATORA	BL.



			HR(H	- INIT-	יוישושטשוו	. 14	ICATE OF BEATH							
197	1 -	STATE III CH REGISTRAR	OKCII.	or. MES	LEIGIAL OIGT	CERTIF								
		OR PRINT)	FIRST		MIDDLE		AST	20. DATE OF DEATH	MONTH DAY	YEAR 2b	HOUR			
death			PAUL	FE	RDINAND	AM	ANN	DECEMBER	13,1985	6:	45 A M			
ter	3. SE)	(4. RACE		5. DATE C		6 AGE (IN YEARS LAST BIR	MONTH IF UN		UNDER 24 HRS			
01	Ma	ale		White		12 MONTH	30 1907	77	YRS.	13 0413	JOKS MIN.			
36	- (RTHPLACE (STATE OR COUNTRY) Aryland	FOREIGN	76 CITIZEN OF	WHAT COUNTRY	/? 8 MARRIE WIDOWE	D NEVER MARRIED DIVORCED	9 BALTIMORE CITY O		гү				
級	111	TY OR TOWN OF DE.	ATH	(IF NOT IN SUC	HOSPITAL, NURS EN FACILITY, GIVE STRE DHEART	ET ADDRESS)	OR OTHER INSTITUTION	120 USUAL OCCUPATION OF WORK FOR MOST OF WESTV	DE WORKING LIFE) IN	126. KIND OF BUSINES INDUSTRY Paper				
36	13a. S	AL RESIDENCE (IF NUR.	13b COUN	OTHER INSTITUTION NTY	GIVE RESIDENCE BEFO 13c. CITY OR TO Western	WN	13d. INSIDE CITY LIMITS? YES NO []	13e STREET ADDRESS A	13e.STREET ADDRESS / ZIP CODE 274 Main St. 2156					
/worling		John Amann LAST Annie						AME	Kady	LAST				
1 86		60 WAS DECEASED EVER IN U.S. ARMED FORCES? 166 SOCIAL SECURITY NO. 17 INFORMANT				ADDRE								
thy section by as an analysis of a second section of a second sec		yes	WW2	C TOTAL OIL DATES,	217-05-	-0113	Mrs. Elizab	eth Amann W	Vesternpo	ort, M.	d 215			
		18 CAUSE OF DEAT	H Enter or	ly ane cause per	line for (a), (b),	and (c)	1			APPROXIMAT BETWEEN ONSE	T AND DEATH_			
		PARI I. DEATH V		TE CAUSE (a)	Conce	noma	lun			3 m	20.			
than c		Canditions, if any		DUE 10, 0	r as a conseq	UENCE OF	7							
please remove co		gave rise to im- cause (a), statu underlying cause	mediate ng the e last.	{ DUE TO, O	r as a conseq	UENCE OF	NOT BELATED TO THE YEA	MIN AL DISEASE OF CON	DITION CIVEN IN	N PAPT 1/a				
to buriol crematian cinjury, or other trauma	NO	gave rise to im- cause (a), statu underlying cause	mediate ng the e last.	{ DUE TO, O	r as a conseq	UENCE OF	NOT RELATED TO THE TER.	MINAL DISEASE OR CON	DITION GIVEN IN	N PART Ito				
rene prior to burio. Eremotian a nows any injury, or ether trauma	TIFICATION	gave rise to im- cause (a), statu underlying cause	mediate ng the e last. NIFICANT (DUE TO, O	R AS A CONSEQ	UENCE OF	NOT RELATED TO THE TER	MINAL DISEASE OR CON 200 AUTOPSY? YES	DITION GIVEN IN 20b. IF YES, WE IN CERTIFYING YES	RE FINDINGS CAUSES OF				
item 18 shows any injury, or after trauma	CAL CERTIFICATION	gave rise to im- cause (a), statu underlying cause PART 2 OTHER SIG	mediate ng the e last. NIFICANT C	(b)	R AS A CONSEQ ONTRIBUTING TO	DEATH BUT	N WAS PERFORMED	200 AUTOPSY?	20b. IF YES, WE IN CERTIFYING	RE FINDINGS G CAUSES OF	DEATH?			
shows	MEDICAL CERTIFICATION	gave rise to imcause (a), stating underlying cause PART 2 OTHER SIGN 19a DATE OF OPERA 21a, ACCIDENT WAS UN OR CONTRIBUTING	MEDICAL EXAMINER	(b)	ONTRIBUTING TO	DEATH BUT TH OPERATIO DAY YEAR 19	N WAS PERFORMED	200 AUTOPSY? YES NO	20b. IF YES, WE IN CERTIFYING YES THE STATE OF THE STATE	RE FINDINGS G CAUSES OF	DEATH?			
shaws any injury.		gave rise to imcause (a), stating underlying cause PART 2 OTHER SIGN 19a DATE OF OPERA 21a, ACCIDENT WAS UN OR CONTRIBUTING (IF EITHER, NOTIFY MED) 21d, INJURY OCCUR WHATE AT WORK NOT WAT WORK 22a 1 certify that (1) saw the decas	mediate mediate mediate mediate. NIFICANT (VIION IDERLYING CAUSE OF DEAL EXAMINER RED HULE CONTROLL STANDARD) (this hospi	(b)	ONTRIBUTING TO ITION FOR WHICH OF INJURY M. MONTH M. OF INJURY REEL, FACTORY, OFFICE the deceased from	DEATH BUT THE OPERATIO DAY YEAR 19 19 19 19	N WAS PERFORMED 21c. HOW INJURY OCCUI	200 AUTOPSY? YES NO RRED (ENTER NATURE OF INJU	20b. IF YES, WE IN CERTIFYING YES THE TITLE TH	RE FINDINGS G CAUSES OF OR PART 2)	DEATH? NO STATE			
ched for use as the burial-transit permit. Then i Sept. of Health and Mental Hygiene prior to but Hem 21 is marked ar Item 18 shows any injury.		gave rise to imcause (a), stating underlying cause PART 2 OTHER SIGN 19a DATE OF OPERA 21a, ACCIDENT WAS UN OR CONTRIBUTING (IF EITHER, NOTIFY MED) 21d, INJURY OCCUR WHATE AT WORK NOT WAT WORK 22a 1 certify that (1) saw the decas	mediate mediate mediate mediate. NIFICANT (VIION IDERLYING CAUSE OF DEAL EXAMINER RED HULE CONTROLL STANDARD) (this hospi	(b)	ONTRIBUTING TO ITION FOR WHICH OF INJURY M. MONTH M. OF INJURY REEL, FACTORY, OFFICE the deceased from	DEATH BUT H OPERATIO DAY YEAR 19 ., FARM, ETC.)	211 LOCATION STREET 19 10 that in (my) (aur) apiniar DEGREE ATTENDING	200 AUTOPSY? YES NO RRED (ENTER NATURE OF INJU	20b. IF YES, WE IN CERTIFYING YES DIRY IN ITEM IS PART I O	RE FINDINGS OF CAUSES OF PART 2) COUNTY That the cause of the cause	DEATH? STATE (It (we) last sess stated			
ched for use as the buriot-transit permit. Then Dept. of Health and Amental Hygiene prior to but tem 21 is marked or Item 38 shows any injury.		gave rise to imcause (a), stating underlying cause PART 2 OTHER SIGN 19a DATE OF OPERA 21a ACCIDENT WAS UN OR CONTRIBUTING (IF EITHER NOTHY MED) 21d INJURY OCCUR WHILE NOTW AT WORD 22a 1 certify that (I) saw the decease above. (I) (we) (2) 22b SIGNATURE	MIFICANT (ATION ATIO	DUE TO, O (c) 19b. CONDITIONS CO 19b. CONDI	ONTRIBUTING TO ITION FOR WHICH OF INJURY M. MONTH M. OF INJURY REEL FACTORY, OFFICE de deceased from after death.	DEATH BUT H OPERATIO DAY YEAR 19 ., FARM, ETC.)	216. HOW INJURY OCCUI 211 LOCATION STREET 19 and that in (my) (aur) apiniar DEGREE ATTENDING PHYSICIAN 226. ADDRESS	200 AUTOPSY? YES NO CITY OR TO CITY OR TO MEDICAL STAL DIRECTOR PHYSIC	20b. IF YES, WE IN CERTIFYING YES THE STATE OF THE STATE	RE FINDINGS G CAUSES OF DOR PART 2) COUNTY Tham the cau 221. DATE SIG	STATE I (I) (we) last sees stated NED			
grene prior to bu	MEDICAL	gave rise to imcause (a), stating underlying cause PART 2 OTHER SIGN 19a DATE OF OPERA 21a ACCIDENT WAS UN OR CONTRIBUTING (IF EITHER NOTHY MED) 21d INJURY OCCUR WHILE NOTW AT WORD 22a 1 certify that (I) saw the decease above. (I) (we) (2) 22b SIGNATURE	MEDONE CAME OF THE	DUE TO, O CONDITIONS CO 19b. COND 19b. CO	DOTRIBUTING TO ITION FOR WHICH OF INJURY M. MONTH M. OF INJURY REEL FACTORY, OFFICE after death.	DEATH BUT THE OPERATION DAY YEAR 19 E. FARM, ETC.)	216. HOW INJURY OCCUI 211 LOCATION STREET 19 and that in (my) (aur) apiniar DEGREE ATTENDING PHYSICIAN 226. ADDRESS	200 AUTOPSY? YES NO NO CITY OR TO CITY OR TO MEDICAL STAI DIRECTOR PHYSIC	20b. IF YES, WE IN CERTIFYING YES THE STATE OF THE STATE	RE FINDINGS G CAUSES OF DOR PART 2) COUNTY Tham the cau 221. DATE SIG	STATE I (I) (we) last sees stated NED			

THE REPORT OF THE PROPERTY OF	OFFICER 13, 1985 - 5:45 A		1937 1 144	
	7	7001 - 00	9	first.
Hand Torus 1980 1980 x 174 to in the last of the last		9,0		
				5 1111
	271 - In 21. 21562	X		land.
		othi		

THE REPORT OF THE CHARLES LAND, IN. CLEAR IN months In the relief washing and

may be

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

the death certificate be

TO FUNERAL DIRECTOR: After this certificate has been signed by the should be detached for use as the burial-transit permit. Then please with the State Dept. of Health and Mental Hygiene prior to burial, cr

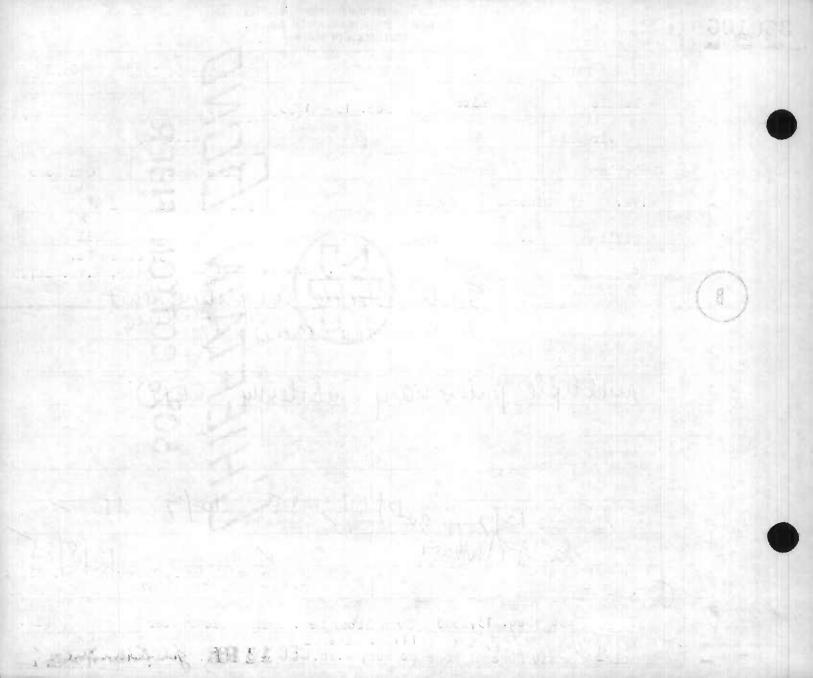
DHMH - 16 60M 7/84 (VRA 15, 4)

MPORTANT: If them 21 is marked or them 18 sta-

ector, page 3

STATE OF MARYLAND

	1-	FOR STATE REGISTRAR			DEPA	RTMENT OF H	ICATE OF I		REG. I	۷٥.	V.3	
		CEASED NAME	FIRST		MIDDLE		AST		20. DATE OF DEATH	MONTH	OAY YEAR	26 HOUR
		Pl	RUDY		L.	ANDER	SON		December	7, 1	985	7:35 pM
	3 SEX			4 RACE		5. DATE C		YEAR	6 AGE (IN YEARS LAST B	RTHDAY)	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
1		Female		W.	hite	De	4 00	1895	89	YRS		HOURS MIN.
2		IRTHPLACE (STATE OR F	OREIGN	76 CITIZEN OF	WHAT COUNT	RY? 8	D NEVER	MARRIED []	9. BALTIMORE CITY	OR COUN	TY OF DEATH	
2		Virg:	inia		USA	WIDOWE		VORCED [A.	llega	ny	MD.
1	0. CI	ITY OR TOWN OF DEA	TH		HOSPITAL, NU	RSING HOME C	OR OTHER INS	TITUTION	12a USUAL OCCUPA			F BUSINESS OR
4	1.6	Cumberland		M	emorial			Bi vi	Homema			wn Home
5	13a. S	AL RESIDENCE (IF NURS. STATE W. Va.	3P CON	other institution ity ineral	13c. CITY OR T		13d. INSIDE C	ITY LIMITS?	13e.STREET ADDRESS			9999
21	IV. FA	ATHER'S NAME FIRST		MIDOLE	LAST		15. MOTHER	MAIDEN NA	ME		1	
1		William		E.	Par	ks	5	Sarah	MIDDLE		Hal	
2		VAS DECEASED EVER			166 SOCIALS		17 INFORMA	NT	ADDI	RESS Q7	James S	
/		N O	(IF 4ES, GIV	E WAR OR DATES]	236-76	-0996	Mr.	Herber	t Anderson		vser. W.	
7	CETTIFICATION	Conditions, if ony, gove rise to imm cause (o), stating underlying couse PART 2 OTHER SASK	which nediote g the lost.	DITIONS CO	R AS A CONSE		en	both	INAL DISEASE OR COL	120b. IF	ES, WERE FINDIN	NGS USED
	TIE			100					YES NOT		TIFYING CAUSES	OF DEATH?
2	MEDICAL CE	210. ACCIDENT WAS UND OR CONTRIBUTING C (IF EITHER NOTIFY MEDIC	AUSE OF DEA	P.	M. MONTH M.	DAY YEAR			RED (ENTER NATURE OF IN)	URY IN ITEM 1	B PART I OR PART 2)	Penno ²
i	MED	21d INJURY OCCURR WHILE NOT WHI AT WORK AT WOR	ILE 🗍	21e PLACE (AT HOME STI	OF INJURY REET FACTORY, OFF	ICE FARM ETC)	21f LOCATIO)N	CITY OR T	OWN	COUNTY	STATE
		sow the eleceose obove, (1) (we) (d 22b. SIGNATURE		2 - 2	e deceased fro	8 ··	od that in (ny)	(our) opinion (death occurred on the	dote and h	pur and from the	, /
		C	how	AVI	alles	7	A	TTENDING PHYSICIAN	MEDICAL STA	CIAN [12	8 82
		22d. PHYSICIAN'S NA	ME (TYPE OF	R PRINT)			22e ADDRES	200 11	emorial Av			Med. Bldg
		Dr. Raver							rland, MD	2150	2	
	230	URIAL, CREMATION, I		23b. DATE		3c NAME OF CE			23d LOCATION CITY OR TOWN		COUNTY	STATE
	14.72	Entomb	nent	Deg.	3,1985	Sylvan	Abbey !	Mem. Pa	irk Clear			s'Fla.
	7	ERAL DIRECTOR	U- /	e Funer	AZ HOME	ss 111 S E Keyse:			A 3 ROS.	Julian	STRAR'S SIGNAT	ure



STATE OF MARYLAND

7FIGLER FUNERAL HOME

MARKET AND THE STATE OF THE STA * A 2011 - Sher D REMEMBER D North - 2105 A ALLEGAM OTATIV PENATO ESPENA, 145 - 190 SETOL ESTAL, CURRENLAND, NO 21502

SILKOX MERRITT FUNERAL HOME STATE OF MARYLAND 50404 DECATOR STREET DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REGISTRAR CUMBERLAND, MD 21502 REG. NO DECEASED NAME LAST 20 DATE OF DEATH MONTH 26 HOUR TYPE OF PRINTI **ELIZABETH EDNA** BARRY DECEMBER 11. 1985 1:50 4 RACE 5. DATE OF BIRTH 6 AGE (IN YEARS LAST BIRTHDAY) IF UNDER I YEAR 3. SEX MONTH YEAR FEMALE WHITE NOVEMBER 20 1911 TO BIRTHPLACE ISTATE OR FOREIGN 76 CITIZEN OF WHAT COUNTRY? 9. BALTIMORE CITY OR COUNTY OF DEATH MARRIED KNEVER MARRIED MARYLAND DIVORCED [ALLEGANY COUNTY WIDOWED 10 CITY OR TOWN OF DEATH NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 12ª USUAL OCCUPATION 17h KIND OF BUSINESS OR (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) TYPE OF WORK FOR MOST OF WORKING LIFE) INDUSTRY SACRED HEART HOSPITAL CUMBERLAND HOUSEWIEE USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13g. STATE 136 COUNTY 13e.STREET ADDRESS / ZIP CODE 13c CITY OR TOWN 13d. INSIDE CITY LIMITS? MARYLAND ALLEGANY CUMBERLAND 9 RIDGEWAY TERRACE YES X NOF 14 FATHER'S NAME 15 MOTHER'S MAIDEN NAME MIDDLE LAST JAMES BESSIE MILLER LEE VALENTINE 160 WAS DECEASED EVER IN U.S. ARMED FORCES? 166 SOCIAL SECURITY NO 17 INFORMANT (YES NO OR UNKNOWN) (IF YES GIVE WAR OR DATES) 217-10-6986 JAMES P. BARRY 9RIDGEWAY TERRACE CUMBERI NO BETWEEN ONSET AND DEATH 18 CAUSE OF DEATH Enter only one couse per li PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE Conditions, if ony, which gove rise to immediate couse (a), stating the underlying couse lost PART 2 OTHER SIGNISICAN CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110 CONDITION FOR WHICH OPERATION WAS PERFORMED Me. AUTOPSY 194 IF YES, WERE FINDINGS USED CERTIFYING CAUSES OF DEATH? YES [NO I 31b. TIME OF INJURY TIR ACCIDENT WAS UNDERLYING ... THE HOW INJURY OCCURRED. LEWISE HATURE OF INJURY IN TEM 18, PART II OR PART TO HOUR A.M. MONTH DAY YEAR OF CONTRIBUTING TI CAUSE OF DEATH LIFETHER, NOTIFY MEDICAL EXAMINER: P.M. 19 714 INJURY OCCURRED THE LOCATION THE PLACE OF INJURY COY OF IDEN COUNTY INT HOME STREET FACTORY OFFICE FARM ETC.) 5,5469.7 NOT WHILE 22x.1 certify that (1) (this hospital) attended the deceased free snw the deceased give on of that in (my) (our) opinion death occurred on the fate and hour and from the course stated above (?) (we) (did) (did not) yew the 27h SIGNATURE DEGREE 27c DATE SIGNED ATTENDING PHYSICIAN TORECTOR PHYSICIAN 27d. PHYSICIAN'S NAME LITYPE OR PRINTS 22e ADDRESS V. RUAL FELIPA, MD 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502 230. BURIAL, CREMATION, REMOVAL 23c NAME OF CEMETERY OR CREMATORY ST MICHAEL'S CEMETERY FROSTBURG ALLEGANY MARYLAND (SPECIFY) BURTAL DEC 13 1985 24 FUNERAL DIRECTOR DHMH - 16 60M 7/84 SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD (VRA 15, 4)

STUCKY (CERTIFICATION AND ESTABLE STUCKES IN COLUMN 351336 CURRENTAL OF STREET A 02:1 2801 .LL RIPEDRO YARAR AKE HERAKLIS ENTERIOR YMASELLIAE F25 BISHOP VALCY ROAD, CATHERLAYO, ND 87502 V. RIPL FELLIN, VO. of 16 8 3 B. Julian Share James

FOR STATE REGISTRAR

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1		EASED NAME FIRST		MIDDLE	ı	AST	2a DATE OF DEATH	MONTH D	DAY YEAR	26 HOUR
ı		SUSAN		ADELE		BATES	DECEMBER 9	.1985		11:45A
1	1. SEX		4. RACE	TELLE	5. DATE C		6. AGE (IN YEARS LAST BIR	THDAY)	IF UNDER 1 YEAR	IF UNDER 24 HRS
	Fe	male	Black		Jur	ne 18 1932	53		ONTHS DATS	HOURS MIN.
	Ju. 8.0	ETHPLACE (STATE OR FOREIGN		WHAT COUNTRY?	0		9 BALTIMORE CITY C	R COUNTY	OF DEATH	
7	10	Maryland	U	SA	MARRIE	D NEVER MARRIED A	Allegany			MD.
7	10 CH	TY OR TOWN OF DEATH			G HOME C	OR OTHER INSTITUTION	120 USUAL OCCUPAT	ION	12b. KIND O	F BUSINESS OR
1		MBERLAND	MEMOR:	TAL HOSPI	CAL	films on a second	Teacher's	s Aid	e Educ	cation
'n	13a S		YTAUC	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	13e STREET ADDRESS	ZIP CODE	21502	Home:
f	Ma	ryland All	egany	Cumber	land	YES X NO	Apt. 7-D	For	t Cumb	perland
1	14 FA	THER'S NAME	MIDDLE	LAST		15. MOTHER'S MAIDEN NAM	ME MIDDLE	19.75	LAS	,
f.	150	Ernest	0.	Bates		Florence			Jor	
		AS DECEASED EVER IN U.S.	ARMED FORCES?	166 SOCIAL SECU	RITY NO.		nberlana,	Md.2		
1		No	GIVE WAR OR DATES	217-30-19	945	Nancy Bates				
		18 CAUSE OF DEATH (Ente	i anly one cause ne	line for (a), (b), and	ic ·			Literatur	APPROXI.	MATE INTERVAL
		PART I. DEATH WAS CA	USED BY:	Adva	nle	d Ca. tr	neno		BET THE ETT	AND ELEMINA
		IWWEL				**				
		Conditions if any which		R AS A CONSEQUE	NCE OF					
		Canditians, if any, which gave rise to immediate								
		cause (a), stating the underlying cause last		R AS A CONSEQUE	NCE OF					
		DADE OTHER SIGNATION	(c)							
	z	PARI Z OTHER SIGNIFICAT	AL CONDITIONS C	ON IKIBUTING TO D	EATH BUT	NOT RELATED TO THE TERM	INAL DISEASE OR CON	DITION GIVE	EN IN PART TO	a
d	ATIC	19a DATE OF OPERATION	19h COND	ITION FOR WHICH	OPERATIO	N WAS PERFORMED	200 AUTOPSY?	T20h JF YES	WERE FINDIN	VGS LISED
Ŧ	CERTIFICATION						YES TO NOT	IN CERTIFY	YING CAUSES	
0	283	21g. ACCIDENT WAS UNDERLYING	21b. TIME C	OF INJURY		21c. HOW INJURY OCCURR		_		140
91	2.1	OR CONTRIBUTING CAUSE OF	DEATH	M. MONTH DA						
	MEDICAL	(IF EITHER NOTIFY MEDICAL EXAM		M. OF INJURY	19	211 LOCATION				
	*	NOT WHILE AT WORK		REET, FACTORY OFFICE, FA	RM ETC)	STREET	CITY OR TO	WN	COUNTY	STATE
		22a I certify that (1) (this he	assital) attended th	a deceased from		. 19	, ta	1	10	that (1) (we) last
		saw the deceased alive	OH.	10.		nd that in (my) (aur) apinian a				
		obove, (Julyes) did (die 225 SIGNATURE	hat yew the body	ofter death.		DEGREE	/		22c DATE	1
			1	Mr	1	ATTENDING	MEDICAL STA	FF _	120	1180
۲		2d. PHYSICIAN'S NAME ITS	PE CAPRING)	1 - 74	_		DIRECTOR PHYSIC			
		DR. ZAMAN				MEMORIAL HOSE			ILDING	
-			Via Ton Sura	100	1445.05.0	ICUMBERLAND, N	MARYLAND 173d LOCATION	2150)2	
	230 8	URIAL, CREMATION, REMOV				EMETERY OR CREMATORY	CITY OR TOWN		COUNTY	STATE
	24 511	Burial	12-12	-85 Bur	set	Memorial P.	Cumberla			
	24. FU	INERAL DIRECTOR Cumb	erland,	Md . ADD 2.15	02		REC'D. BY REGISTRAR		4	
	Le	asure-Stein	Inc. 2	30 Balti	more	Ave.	1 3 1985 1	would still	4days-1/p	nouse

DHMH - 16 60M 7/B4 (VRA 15, 4)

Advanced Ca torque

357043	THAFER FUNERAL HOME 1 - STATE 1302 NATIONAL HWY. REGISTRALAVALE, MD 21502 1. DECRASED NAME FIRST MIDDLE LAST					NE REG. NO	3 2	7 9	- Special Control of the Control of				
The Malling			FIRST		MIDDLE	(AST	2	o. DATE OF DEATH		AY YEAR	2b HOUR	
of the be	(TYPE		AUL T	HEODORE	BECKWITH			- 1	DECEMBER 1	5, 198	35	2:37	A
poge er dept	3. SE)			4. RACE		S. DATE C			AGE (IN YEARS LAST BIR	_	IF UNDER 1 YEAR	IF UNDER 24 H	RS
ctor s oft	M	ale		White		Month	29- 1903		82	YRS.	DATS	HOURS M	IN.
- 2 42 NV	7a. Bi	RTHPLACE LITATE OF	FOREIGN		WHAT COUNTRY?	8.		9	9 BALTIMORE CITY OR COUNTY OF DEATH				
1 11 5/1	1	Ohio		U.S	Α 2	WIDOWE	D NEVER MARRIED		ALLEGANY	COUNT	ſΥ		MD.
1 11 10	10 E	TY OR TOWN OF DEA	ATH	11. NAME OF			OR OTHER INSTITUTION		128 USUAL OCCUPATION 126. KIND OF BUSII			F BUSINESS	OR
5 5 50	1	Cumberlar	nd	7.1.	HEART HO		1	Rigger		, MOKKING THE		factu	rin
		AL RESIDENCE (IF NURS		ROTHER INSTITUTION		ADMISSION)	13d. INSIDE CITY LIMI	ITS2 1	3e.STREET ADDRESS	ZIP CODE	4	199	34
S E E		Ohio	Tru		Niles		YES NO		10 Sheri		ve 12	1502/	
是 學別生	Ja FA	THER'S NAME		WIDDLE	LAST		15 MOTHER'S MAIDE	ENNAME	MIDDLE		LAS	1	-
WW S TO THE	0	Frank		MUOLE	Beckwit	h	Emma					Mill	er
and the same of th		VAS DECEASED EVER		RMED FORCES?	16b. SOCIAL SECU		17. INFORMANT		ADDR	SS			
IMO S S S S S S S S S S S S S S S S S S S		No	(# 123, 6)	VE WAR OR DATES;	220-10-9	091	Agnes S.	. Be	ckwith s	ame a	as abo	ve	
BALT Score & Score & S		18 CAUSE OF DEAT PART I. DEATH W			Cardio	dict.	1: A Line	20.	Parke.		BETWEEN O	ONSET AND DEA	TH _
TS ST	1		IMMEDIA	TE CAUSE (o)			hundry	700	2000-00	- N	100	1	
OTS 62 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6		Canditians, if any	which	DUE TO, C	R AS A CONSEQUE	ENCE OF	Conchral	dry	lavetim		100		
hot the ch by the of ase retto I, cremit		gave rise to imicause (a), stotii underlying cause	mediate	DUE TO, C	BA CONSEQUE	ENCE OF	EVA. Cano	40	artirio 8ch	nosis			
PRDS, 20	CATION	Dialecter	mel	liks .: S	epticem	in C	NOT RELATED TO THE		acuti Res	ul 70	ilme	, old a	ye
DIVISION OF VITAL RECORDS, NG PHYSICIAN: The low requir offer this certificate has been signs as the burial-transit permit. Then though Mental Hygiene prior to be an orked or them 18 shows any injur	<u>-</u>	19a. DATE OF OPERA	TION	IN COND	DITION FOR WHICH	OPERATIO	IN WAS PERFORMED		200 AUTOPSY?		, WERE FINDIN YING CAUSES		
VIT. Thysici transitions in the shift of the	CERTI	210. ACCIDENT WAS UN	b.	110110 4	OF INJURY .M. MONTH D	AY YEAR	21c HOW INJURY O	CCURRE	D (ENTER NATURE OF INJU	RY IN ITEM 18 PA	ART 1 OR PART 2)		
OF ICIA Bertiff Particular Intelligible Inte	SAL	OR CONTRIBUTING		AIR	.M.	19							
HYS ndin his of hour	MEDICAL	21d. INJURY OCCUR			OF INJURY	ARM FIC	211 LOCATION STREET		CITY OR TO	WN	COUNTY	STATE	
MA STAN	2	AT WORK AT WO	HILE									MEDICE.	
TENDIN ortol or TOR: Al for use of thealt		saw the decease above, (1) (we)/				5.0	6 85, 19 nd that in (my) (aux) ap	pinian de	ath accurred an the d	ate and have		that (I) (we) causes stated	
OR A he hosp DIREC toched to Dept.		22b. SIGNATURE	C/	Can de la característica de la	JI. M	9	DEGREE ATTENDI	ING	MEDICAL STA		22c. DATE	SIGNED STIPA	95
ERAI Stote		22d. PHYSICIAN'S N	AME (TYPE	OR PRINT)	sum I	w	T-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1		DIRECTOR PHYSIC		1 /	7110	
HOSPIT. HOSPIT. Build be a mith the Sic	1	SIKANDER	SAND	HIR				FROS	ARN TERRAC TBURG, MD	21532	2		
9999BP		BURIAL, CREMATION,	, REMOVAI	Dec.			EMETERY OR CREMAT	TORY	23d. LOCATION CITY OR TOWN	rumbi	YINUOD	STATE	
DHMH - 16 50M 4/B3 (VRA 15, 4)		ohn J. H	afer				25	DE		25h REGISTI	AR'S SIGNAT	URE	

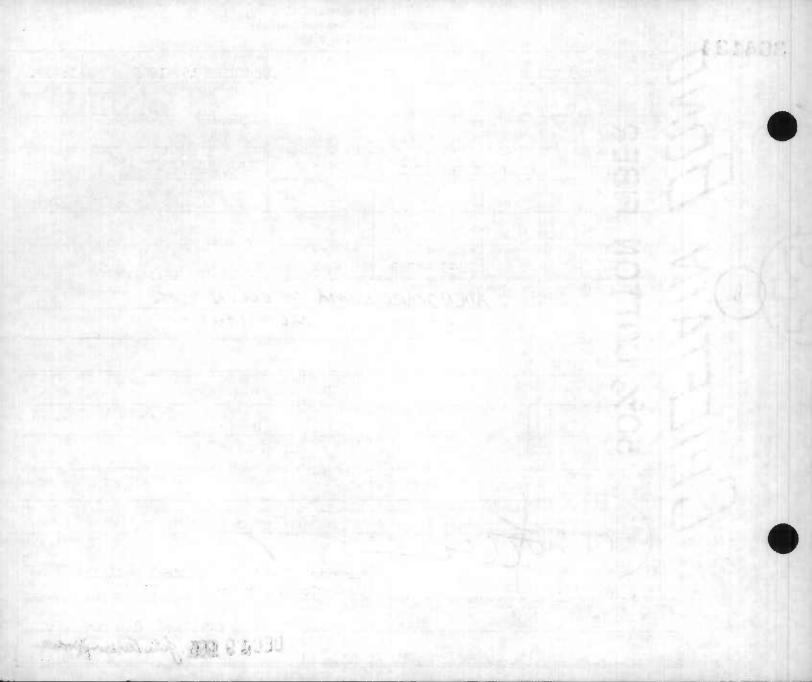
DECEMBER IN INSS. 2007 A COLO MANAGLIA COLO DE MINISTER SACRED HEART HOSFITAL REPORT TAKEN CHOOSE STORES COUNTY of Birand Of X - A - A - Indiana of other TOTAL PRINCIPLE CONTRACT CONTR 228-10-9021 tqnes S. Buckwith some as above Harred Verren Trumbull Chic. 17, 25 Fineview Verren Trumbull Chico

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR				CERTIF	ICATE OF DEATI	Н	REG. NO).		
	EASED NAME	FIRST		MIDDLE		LAST		20. DATE OF DEATH		Y YEAR	2h HOUR
11174	De selecti.	KATHL	EEN	MAE	BIE	ERMAN	b	ECEMBER 16	, 1985		1:45P.M
3. SEX			4 RACE			OF BIRTH		6. AGE (IN YEARS LAST BIRT		UNDER I YEAR	
1	female		whi	ite	MONT	09-08-1916	AR	75	YRS	NIHS DAYS	HOURS MIN.
	OUNTRY	R FOREIGN		WHAT COUNTRY?	B.	D NEVER MARRI		BALTIMORE CITY O	COUNTY	FDEATH	
	WV		USA	A	WIDOW			Allegar	ıy		MD.
M CI	TY OR TOWN OF D	EATH	11. NAME OF I	HOSPITAL, NURSIN	G HOME	OR OTHER INSTITUTION	NC	12a USUAL OCCUPATIO		12b. KIND C	OF BUSINESS OR
CI	JMBERLAND		MEMORIA	AL HOSPIT	AL			nousewif	е	OWN	home
	L RESIDENCE (IF NO	13h COUN	OTHER INSTITUTION	GIVE RESIDENCE BEFORE		1 13d INSIDE CITY LIA	Alts?	13e.STREET ADDRESS /	71P CODE		
	MD	All	.egany	Cumberl	and .	YES NO		R.F.D. 4	- Mex	ico Fa	arms/2150
4 FA	THER'S NAME	150	MIDDLE	LAST		15. MOTHER'S MAIL	DEN NAM	E MIDDLE		LAS	57
	C	liftor	n E. Wil	lison		11831	Cora	M. Emerick			
	AS DECEASED EVE		MED FORCES?	166 SOCIAL SECU	RITY NO.	17. INFORMANT		ADDRE			
	no	1		217-10-4	783	Mr. Frede	rick	W. Bierman	,Jr.,		
	18 CAUSE OF DEA	TH (Enter on	ly one cause per	line far (a), (b), and	d ic				.,	BETWEEN	ONSET AND DEATH
	PARTI. DEATH		E CAUSE (a)	ADENOG	ARCI	NOMA	or c	ASTASIS.	ith		
-			DUE TO, O	R AS A CONSEQUE	NCE OF	1	NETT	45TAS15 .		7.0	
100	Canditians, if ar	ny, which	(ıb)					ALL SERVICE			
	gave rise to in cause (a), sta	ting the	DUE TO, OI	R AS A CONSEQUE	NCE OF						
	underlying cau	se last.	((c)		13:05						
,	PART 2 OTHER SIG	GNIFICANT	ONDITIONS CO	ONTRIBUTING TO D	EATH BUT	NOT RELATED TO TH	HE TERMIN	NAL DISEASE OR CONE	ITION GIVEN	IN PART 1	o
CERTIFICATION											
9CA	190 DATE OF OPER	ATION	196 COND	ITION FOR WHICH	OPERATIO	N WAS PERFORMED		200 AUTOPSY?	IN CERTIFY	WERE FINDING CAUSES	NGS USED OF DEATH?
2.TE			2 400 500 5			100 11001111111111111111111111111111111		YES NO	YES		NO 🗆
	21a. ACCIDENT WAS U	-	216. TIME O HOUR A.	m. Month da	YEAR	TIE HOW INJURY	OCCURRE	D (ENTER NATURE OF INJUR	IN ITEM 18 PAR	T I OR PART 2}	
MEDICAL	(IF EITHER NOTIFY ME				19						
MED	21d INJURY OCCU		21e. PLACE	OF INJURY REET, FACTORY, OFFICE, F	ARM, ETC)	211 LOCATION STREET		CITY OR TOV	VN.	COUNTY	STATE
5	wit sedilek	AOKK .	1								
	22a I certify that a			e deceased from		, 19.					that (I) (we) last
	abave, (l) (we)	(did) (did no	1) vie The bady	ofter death.			apinion as	eath accurred on the da	le and hour o		
	Th SIGNATURE	1	OV C	01		DEGREE	DING /	MEDICAL _ STAF	F	22c. DATE	SIGNED
	THE PASHCIAN'S	NAAAE JUUR O	X	1				DIRECTOR PHYSIC		17.71	
			IK PERSONAL PROPERTY OF THE PR			Memorial	-		ical B		ıg
17	DR. TORR					Cumberla			215	02	
	URIAL, CREMATION					EMETERY OR CREMA		23d LOCATION CITY OR TOWN		COUNTY	STATE
24 51	Buri	aı	12-19-	1985 Hi	llcre	est Burial	Park				y MD
	NAME			ADDRESS			DE	REC'D BY REGISTRAR	Sula D		Handelle.
	James F.	Scarpe	Ili, Cur	mberland.	_MD_2	21502			1		2 mars

DHMH - 16 60M 7/84 (VRA 15, 4)



STATE OF MARYLAND

147 78 747	T CV	Bo. a	Challes	based 3	
		TOUR OF THE MA	nttill		
TRIE LEADER		enon partitud of	nIIIV temer noo	Chi Marina	
	ASS Velley Set			malia bu	lezh.
	-simily and			roll entacts T	
Alipake Dr	plant to the beat w	dealer and top	F-0.0-7.19		
-12-4					

desires . Lorgo Dd. Herender of Low en OE 0.29 The finisher from

		CEASED NAME FIRST	- HWY. LA	DDLE	ı	AST		REG. NO		AY YEAR	2b HOUR
6		ALI	CE J	UNE	BOWMA	N		DECEMBER	9,1985		2:35 RA
-	3 SE		4 RACE		5. DATE C	DAY	VEAD	GE (IN YEARS LAST BIR	THDAY) II	FUNDER 1 YEAR	IF UNDER 24 HRS HOURS MIN.
61	1	Female IRTHPLACE (STATE OR FOREIGN	Whi		Aug	11, 19	933	52	YRS		
5	/0 b	VA.	US		MARRIE	NEVER MARE	CED	ALLEGAN			MD.
12	1	try or town of death Cumberland	(IF NOT IN SUCH	ED HEAR	T HOSE	TTAL		(TYPE OF WORK FOR MOST OF WORKING LIFE) INC			Home
T	30	STATE 136 CO	legany Cresaptown YES 🕱 NO 🗆			IMITS? 13e	TREET ADDRESS	zip code	ak St.	./21502	
1	14 F.	ATHER'S NAME FIRST	WIDDLE				IDEN NAME	WIDOLE		LAS	ī
1	16.	Harry Ve	rnon	Keseck		Mart 17. INFORMANT	ha	Estel	la l	Fearn	WC
			GIVE WAR OR DATES)	220287			. Bow	man - sa	ame as	s abov	ve
		18 CAUSE OF DEATH (Enter PART I. DEATH WAS CAU	only one couse per le SED BY:	ine (a), (b), o	and ics.	406	an C			APPROXI BETWEEN	MATE INTERVAL ONSET AND DEATH
NO	Conditions, if ony, which	((b)	AS A CONSEOU	UENCE OF	hea	1	- tel	,			
	ATION	Conditions, if ony, which gove rise to immediate couse (o), stating the underlying couse lost. PART 2 OTHER SIGNIFICAN 190 DATE OF OPERATION	DUE TO, OR (c) T CONDITIONS COI	AS A CONSEQUENTRIBUTING TO	DEATH BUT	NOT RELATED TO		DISEASE OR CONI	20b. IF YES,	WERE FINDIN	NGS USED
9	TIFICATION	gove rise to immediate couse (a), stating the underlying couse lost. PART 2 OTHER SIGNIFICAN	DUE TO, OR (c) T CONDITIONS COI	AS A CONSEQUENTRIBUTING TO	DEATH BUT		D 2		20b. IF YES,	WERE FINDIN	NGS USED
177	CAL CERTIFICATION	gove rise to immediate couse (a), stating the underlying couse lost. PART 2 OTHER SIGNIFICAN	DUE TO, OR (c) 19b. CONDIT	AS A CONSEQUENTRIBUTING TO	DEATH BUT	N WAS PERFORME	D 2	0 AUTOPSY?	20b. IF YES, IN CERTIFY YES	WERE FINDIN ING CAUSES	NGS USED OF DEATH?
9	MEDICAL CERTIFICATION	gove rise to immediate couse (o), stating the underlying couse lost. PART 2 OTHER SIGNIFICAN 190 DATE OF OPERATION 210. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF	DUE TO, OR (c) 19b. CONDITIONS COI 19b. CONDIT 21b. TIME OF HOUR A.M P.M. 21e. PLACE O	AS A CONSEQUENTRIBUTING TO	DEATH BUT H OPERATIO DAY YEAR	N WAS PERFORME	D 2	00 AUTOPSY?	206. IF YES, IN CERTIFY YES	WERE FINDIN ING CAUSES	NGS USED OF DEATH?
n 21 is morked or liem 18 shows only injury, or other from		gove rise to immediate couse (a), stating the underlying couse lost. PART 2 OTHER SIGNIFICAN 190 DATE OF OPERATION 210. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF (IF EITHER NOTIFY MEDICAL EXAMPLE ALL WORK AT WORK AT WORK AT WORK 220.1 certify that (1) (this has sow the deceased olive above, (1) (we) (1) (this has sow the deceased olive above, (1) (we) (1) (this lab	DUE TO, OR (c) T CONDITIONS COI 19b. CONDIT 21b. TIME OF HOUR A.M P.M 21e. PLACE O (AT HOME. SIRE!	AS A CONSEQUENTRIBUTING TO SOME SOME SOME SOME SOME SOME SOME SOM	DEATH BUT H OPERATIO DAY YEAR 19 FARM, ETC.)	21c. HOW INJURY 211. LOCATION STREET 21 d that in (my) (our	D 2 Y OCCURRED	OO AUTOPSY? ES NO (ENTER NATURE OF INJUI	20b. IF YES, IN CERTIFY YES RY IN ITEM 18 PAR	WERE FINDING CAUSES RELIGRART 2) COUNTY	NGS USED OF DEATH? NO STATE that (I) (we) lost couses stated
State of the state		gove rise to immediate couse (a), stating the underlying couse lost. PART 2 OTHER SIGNIFICAN 19a DATE OF OPERATION 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF (IF ETHER NOTIFY MEDICAL EXAMINATION OF COURTED WHILE ATWORK OT WHILE ATWORK OT WHILE ATWORK SOW the deceased olive	DUE TO, OR (c) T CONDITIONS COL 19b. CONDIT 21b. TIME OF HOUR A.M P.M 21e. PLACE O (AT HOME. SIRE!	AS A CONSEQUENTRIBUTING TO SOME SOME SOME SOME SOME SOME SOME SOM	DEATH BUT H OPERATIO DAY YEAR 19 FARM, ETC.)	211. HOW INJURY 211. LOCATION STREET 21 d that in (my) (our)	D 2 Y Y OCCURRED	O6 AUTOPSY? ES NO (ENTER NATURE OF INJUIL CITY OR TO	20b. IF YES, IN CERTIFY YES RY IN ITEM 18 PAR	WERE FINDING CAUSES TO THE PART 2) COUNTY POND from the cause of th	NGS USED OF DEATH? NO STATE that (I) (we) lost couses stated
9	MEDICAL	gove rise to immediate couse (a), stating the underlying couse lost. PART 2 OTHER SIGNIFICAN 19a DATE OF OPERATION 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF (IF ETHER NOTIFY MEDICAL EXAMINATION OF COURTED WHILE ATWORK NOT WHILE ATWORK NOT WHILE ATWORK OF COURTED Sow the deceased olive above, (b) (we) (did) (did) 22b. SIGN ATURE	DUE TO, OR (c1) T CONDITIONS COI 19b. CONDIT 21b. TIME OF HOUR A.M P.M 21e. PLACE O (AT HOME. STREET Spitol) oftended the on 22 Q TOTAL PLACE OF PRINT) M.D.	AS A CONSEQUENTRIBUTING TO ION FOR WHICE INJURY A MONTH IN ITEMPERATE IN ITEMPERATE IN ION IN ION ION ION ION ION ION ION I	DEATH BUT H OPERATIO DAY YEAR 19 FARM. ETC.)	211. LOCATION STREET 211 LOCATION STREET 212 ATTEM PHYS 222 ADDRESS	OCCURRED OCCURRED Opinion death NDING M SETON DI	CITY OR TO	20b. IF YES, IN CERTIFY YES RY IN ITEM 18 PAR WN ate and hour a	WERE FINDING CAUSES COUNTY 221. DATE 222. DATE	NGS USED OF DEATH? NO STATE thot (I) (we) lost couses stoted SIGNED

STATE OF MARYLAND

JOSE NAT. BAY. LAVALE, 15. MICHELLINE

					CHAVAL		335F
4 35:3	3.0	okopiler gjas		HAMIOS	350,6	HOLIA	
		Artisen.	eter .	it sails	HILH		
	YTAU	ALLEGANY CO		X	ati		. AV . If
		of Eyesbell /		PT TOSETIME	ALL CLED		one Pradius
St. Arrigot	2/40	26906 Lane		anote		Verma B.I.I.A.	bmalero
	6 3	all star	THE TOP	modification		Verron	
gvod	3 3 6		.1 -6		29182		
			N. N.				
		A Comment					

volle character of the contract of the contrac

Burtol 177/12/85 Cunset Mes. Park Lunde Land, Alleg., Milliand and Land, Alleg., Milliand Lunde Land.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE 353132 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REGISTRAR REG NO 1. DECEASED NAME 20. DATE KNOWN MONTH TTYPE OR PRINTS ESTI-ARY, PLEASE DIRECTOR. OUR FILES. V 72 HOURS BRODBECK DEATH MATED IDA 4 RACE & AGE (IN YEARS | IF LINDER 1 YR 3 SEX 5. DATE OF BIRTH IF UNDER 24 HRS DATE LAST BIRTHDAY) PRONOUNCED 3/15/93 DEAD YRS TO BIRTHPLACE (STATE OF 9. BALTIMORE CITY OR COUNTY OF DEATH MARRIED NEVER MARRIED MARYLAND U.S.A. ALLEGANY WIDOWED DIVORCED 120. USUAL OCCUPATION (TYPE OF WORK 126 KIND OF BUSINESS CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION OR INDUSTRY FOR MOST OF WORKING LIFE) HOUSEWIFE OWN HOME FROSTBURG ING HOME OR OTHER INSTITUTION VE RESIDENCE BEFORE ADMISSIONI 13b. COUNTY 30 STATE 13c. CITY OR TOWN 13d INSIDE CITY LIMITS? 13e STREET ADDRESS NATIONAL ALLEGAN YES 4 FATHER'S NAME 15. MOTHER'S MAIDEN NAME MIDDLE LAST EIRST JANE WARE MARY TAYLOR JRS AFTER DEA B. GIVE PAGES WITH FORM 160 WAS DECEASED EVER IN U.S. ARMED FORCES? 166 SOCIAL SECURITY NO 17 INFORMANT FROSTBURG (YES, NO, OB UNKNOWN) DIVISION HE YES GIVE WAR OR DATES! MRS. NAOMI 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY: PRESTON ST WITH METASTASIS CANCER OF THE RECTUM IMMEDIATE CAUSE (a)_ DUE TO, OR AS A CONSEQUENCE OF Canditians, if any, which gave rise to immediate cause (a) stating the under DUE TO, OR AS A CONSEQUENCE OF lying cause last PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (g) E DEPARTMENT OF HEALTH A
31 PRIOR TO BURIAL, CREMA CERTIFICATION 19g. DATE OF OPERATION 196 CONDITION FOR WHICH OPERATION WAS PERFORMED? 20 AUTOPSY? YES NO T 21g EXTERNAL CAUSE WAS 216. TIME OF INJURY 216 HOW INJURY OCCURRED JENTER NATURE OF INJURY IN ITEM 18 PART LOR PART 2) HOUR A.M. MONTH DAY YEAR UNDERLYING OR CATE, WRITING TH FORWARDED TO T OR: PAGE 3 SHOUL CONTRIBUTING CAUSE OF DEATH PM 19 21e PLACE OF INJURY (ATHOME. 21f. LOCATION STREET, FACTORY, FARM, ETC.) STREET CITY OR TOWN COUNTY STATE WHILE AT WORK EXECUTE THE CERTIFICATE, V PAGE 4 SHOULD BE FORW, TO FUNERAL DIRECTOR: PA AFER DEATH, WITH THE STY BALTIMORE, MARYLAND, 2 22e I certify that I taak charge of the remains described above, held an Autopsy Inspection and in my apinian Natural causes X death resulted fram: Hamicide ___ Acciden Suicide Undetermined manner TITLE (SPECIFY) 12/5/85 ACTUAL SIGNATURE MEDICAL EXAMINER EXAMINER'S NAME ADDRESS 900 Seton Dr. Cumberland Md. FRANCISCO REY (TYPE OR PRINT) 23¢ NAME OF CEMETERY OR CREMATORY 23d. LOCATION 230 BURIAL CREMATION REMOVAL 236 DATE STATE 12/8/85 FROSTBURG FROSTBURG MEM 07/84 BP MD 25M 250. DATE REC'D. BY REGISTRAR 256 REGISTRAR'S SIGNATURE DHMH - 17 FROSTBURG (VR A15 ME (5))

A . AMERICA THE . LOS E LANGE THE ATT

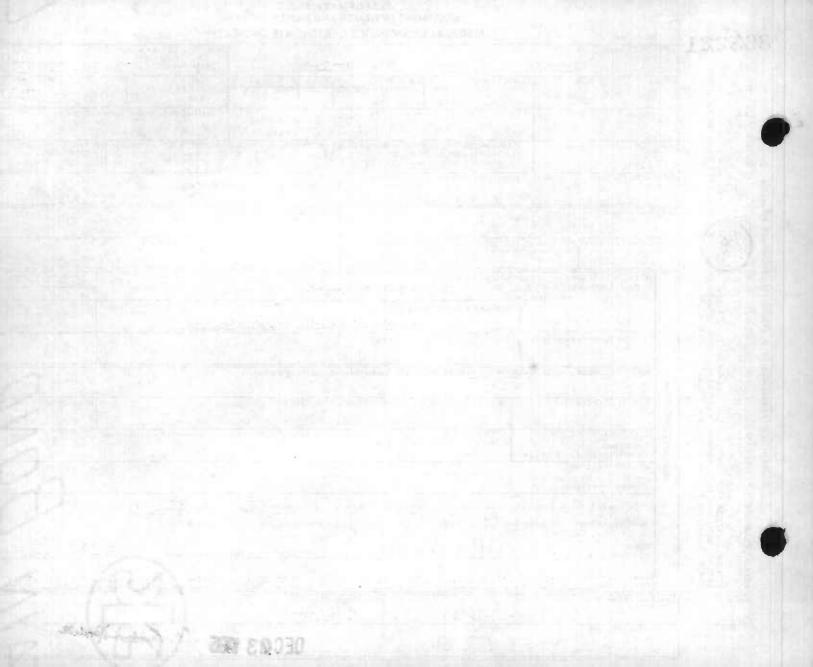
all the state of the state of the

10

DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR - STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH REGISTRAR 365221 . DECEASED NAME OF ESTI-9:50 (TYPE OR PRINT) Burdock Georgia May DEATH MATED 1985 18 4 RACE 6. AGE (IN YEARS IF UNDER 24 HRS DATE LAST BIRTHDAY) PRONOUNCED 9:50 18 1,85 female white 02-14-1918 DEAD 7b. CITIZEN OF WHAT COUNTRY? TO BIRTHPLACE (STATE OR BALTIMORE CITY OR COUNTY OF DEATH MARRIED NEVER MARRIED FOREIGN COUNTRY) Allegany WIDOWED X DIVORCED I. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL NURSING HOME, OR OTHER INSTITUTION 120. USUAL OCCUPATION (TYPE OF WORK 126. KIND OF BUSINESS Cumberland clerk Sacred Heart Hospital Dept. Store JSUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 3a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d INSIDE CITY LIMITS? 13e. STREET ADDRESS Allegany MD Cumberland YES X 925 Grand Avenue/21502 NO [14 FATHER'S NAME 15. MOTHER'S MAIDEN NAME Walter Glaze, Sr. May Davy BALTIMORE 160. WAS DECEASED EVER IN U.S. ARMED FORCES? 166 SOCIAL SECURITY NO. 17 INFORMANT ADDRESS (YES, NO. OR UNKNOWN) 1 (IF YES GIVE WAR OR DATES) Mrs. Anna May Swauger, Bowling Green, 800-05-4394 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY Mycardial infarction due to IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which arteriosclerotic heart disease gave rise to immediate cause (a) stating the under-DUE TO, OR AS A CONSEQUENCE OF lying cause last. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (g) 190. DATE OF OPERATION 19h CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES 🗌 NOXIX 210 EXTERNAL CAUSE WAS 21b. TIME OF INJURY 214. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) HOUR A.M. MONTH DAY YEAR UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 21d. INJURY OCCURRED 21e PLACE OF INJURY LATHOME. 21f. LOCATION STREET, FACTORY, FARM, ETC. CITY OR TOWN COUNTY STATE WHILE AT WORK InspectionXX AGE 4 SHOULD BE FOR TO FUNERAL DIRECTOR: 22a I certify that I took charge of the remains described above, held an Autapsy death resulted fram: Natural causes XX Suicide Hamicide ____ Undetermined manner DATE 12-18-85 EXAMINER'S NAME Giovanni Mastrangelo, M. D. ADDRESS 900 Seton Drive, Cumberland, MD 21502 236. NAME OF CEMETERY OR CREMATORY 23d LOCATION 230 BURIAL, CREMATION, REMOVAL 236 DATE STATE Burial 12-21-1985 Rose Hill Cemetery Thomas WV 250. DATE REC'D. BY REGISTR R 250. REGISTRAR'S NAME 24. FUNERAL DIRECTOR **DHMH - 17** Scarpelli Funeral Home, Cumberland, MD 215 (VR A15 ME (5))

20M 4/82

STATE OF MARYLAND



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

DEC 30 1995 Julie Beindon Rondoll

3. N	10.				
Н	MONTH	DAY	YEAR	2b. HOUR	_

		REGISTRAR				CENTIN	ICAIL OF	PLAIII		REG. N	0.			
		CEASED NAME	FIRST		MIOOLE	ı	AST		20 DATE	OF DEATH	MONTH E	DAY YEAR	2b. HOUR	_
		OR PRINT)	JAMES		ROBERT		FIELD				4, 198		10:25	A
	3. SE)		4.	RACE		5. DATE C		WE 4.0	6. AGE (1	N YEARS LAST BIR		IF UNDER I YEAR	HOURS MIN	_
		male		whit			03-24	-1901		84	YRS.		HOURS MIN	
2	7a BI	RTHPLACE (STATE OR F COUNTRY) WV	OREIGN 76	USA	WHAT COUN	TRY? & MARRIEI WIDOWE		R MARRIED DIVORCED	Δ	iore city <u>c</u> llegan	OR COUNTY	OF DEATH		AD.
1		TY OR TOWN OF DEA	TH 11		HOSPITAL, NU HEACILITY GIVE AL HOS	URSING HOME C STREET ADDRESS) PITAL	OR OTHER IN	STITUTION		OCCUPAT BTAKE	ion Man life		road	R
6	USU/ 13a. S	AL RESIDENCE (IF NURS STATE MD	136 COUNTY Allec	4	13c CITY OR		13d. INSIDE	CITY LIMITS?	13e.STREE	ADDRESS	ojatem 1	n Road/	/21502	
1 3	14 FA	THER'S NAME					15. MOTHE	R'S MAIDEN N						_
		Jame	s R. C	anfiel	d	1.0		Mel	issa A		-	LAS	ıT	
1		VAS DECEASED EVER		ED FORCES?	166 SOCIAL	SECURITY NO.	17 INFORM	MANT	-	ADDRI	ESS			
		yes	1924-		214-0	15-8443	Mrs.	Emma J	. Canf	ield,	Cumbe:	rland,	MD - W.	if
		18 CAUSE OF DEATH PART I. DEATH W		BY:	/	andio 9	enic	shoc	K.			APPROX BETWEEN	IMATE INTERVAL ONSET AND DEATH	
		Conditions, if ony, gove rise to imm cause (a), statin underlying couse	nediate ig the	(b)		EQUENCE OF	e l Oyonar	tout 1	MT Disea	se				
	NO	PART 2 OTHER SIGN	VIFICANT CO	NOTIONS CO	10	Dely cha	NOT RELAT	ED TO THE TER	MINATOISE	SE OR CON	IDITION GIVI	EN IN PART 1	O	
1	CERTIFICATION	190. DATE OF OPERAT	TION	19h/COND	TION FOR W	HICH OPERATIO	N WAS PERI	ORMED	200 AU	TOPSY?	IN CERTIFY	, WERE FINDII YING CAUSES	OF DEATH?	
9		210. ACCIDENT WAS UND OR CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTION	CAUSE OF DEATH	21b. TIME O HOUR A P	M. MONTH	DAY YEAR	21¢ HOW	INJURY OCCU	RRED (ENTER	NATURE OF INJU	IRY IN ITEM 18 PA	ART 1 OR PART 2)		
	MEDICAL	21d. INJURY OCCURE WHILE NOT WH AT WORK AT WOR	ILE 🗆	21s. PLACE		FICE, FARM, ETC)	211 LOCA STRI			CITY OR 10)WN	COUNTY	STATE	
		22a.1 certify that (1)					+	19	, to				that (I) (we) la	st
		sow the decease above, (I) (we) (a	did) did not)	view the body	ofter death	19, or	nd that in (m	y) (our) apinior	n death accu	red on the d	ate and hour	and from the	causes stated	
		22b. SIGNATURE	Of the			M:	DEGREE	ATTENDING PHYSICIAN	MEDICA DIRECTO	L STA		22c. DATE	SIGNED /	5
		Dr. Ranjit		HP4T).				RIAL HO				UILDIN 502	g L	-
	23a B	BURIAL, CREMATION, SPECIF BUTIAL	REMOVAL	23b. DATE 12-2	7-1985	231 NAME OF C	EMETERY O		23d. LO			legany	MD STATE	_
		INERAL DIRECTOR			THE PARTY NAMED IN						0	PAR'S SIGNAT	LIRE	-

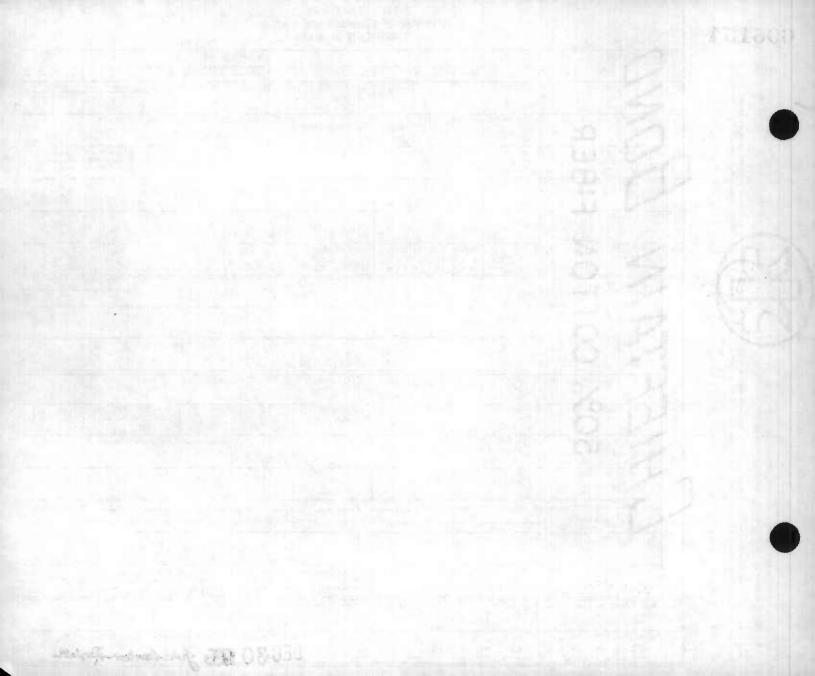
James F. Scarpelli, Cumberland, MD 21502

DHMH - 16 60M 7/B4 (VRA 15, 4)

BP.

TO FUNERAL DIRECTOR: After this certificate has been retained by the hospital or attending physician. The low

MAPORTANT: If Hem 21 is marked or Hem 18 shows any injury, or other traumatic should be detached for use as the burial-transit permit. Then please remave corl with the State Dept. of Heolth and Mental Hygiene prior to burial, crematian, or



- STATE REGISTRAR

MARGARET

4 RACE

I. DECEASED NAME

(TYPE OR PRINT)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO LAST 2a DATE OF DEATH 26 HOUR December 1, 1985 3:50 A GRACE CATHELL 5. DATE OF BIRTH A. AGE (IN YEARS LAST SIRTHDAY) April 9,1916 BALTIMORE CITY OR COUNTY OF DEATH MARRIED NEVER MARRIED Allegany WIDOWED 120 USUAL OCCUPATION 12b. KIND OF BUSINESS OR 13d. INSIDE CITY LIMITS? 13e.STREET ADDRESS / ZIP CODE 62 Vernon St. 15 MOTHER'S MAIDEN NAME MIDDLE Nan (Unknown) Cox 62 Vernon St. 166 SOCIAL SECURITY NO 17. INFORMANT Mr. William E. Cathell Keyser, W.Va. 234-56-5212 20b. IF YES, WERE FINDINGS USED 20a AUTOPSY3

Female White BIRTHPLACE (STATE OF FOREIGN 76 CITIZEN OF WHAT COUNTRY W. Va. USA NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION MEMORIAL HOSPITAL Cumberland USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Minera 13c. CITY OF TOWN 14. FATHER'S NAME George 166 WAS DECEASED EVER IN U.S. ARMED FORCES? 18 CAUSE OF DEATH (Enter only page 18 PART I. DEATH WAS CAUSE) Conditions, if ony, which gove rise to immediate cause (a), stating the DUE TO, OR AS A CONSEQUENCE OF underlying couse lost CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110 CERTIFICATION 196. CONDITION FOR WHICH OPERATION WAS PERFORMED 19a DATE OF OPERATION IN CERTIFYING CAUSES OF DEATH? YES [NO [21b. TIME OF INJURY 21a. ACCIDENT WAS UNDERLYING 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) HOUR A.M. MONTH DAY YEAR OR CONTRIBUTING CAUSE OF DEATH MEDICAL (IF EITHER NOTIFY MEDICAL EXAMINER) 21d INJURY OCCURRED 21e PLACE OF INJURY 21f LOCATION CITY OR TOWN COUNTY STATE (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NOI WHILE 220.1 certify that (1) (this haspital) attended the deceased from and that in (our) opinion death occurred an the date and hour and from the causes stated above. (IV we) (and) did not) view the bady after death DEGREE THE DATE SIGNED ATTENDING PHYSICIAN DIRECTOR PHYSICIAN 22e ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502 James Raver 236. BURIAL, CREMATION, REMOVAL 123b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION STATE

DHMH - 16 60M 7/B4 (VRA 15, 4)

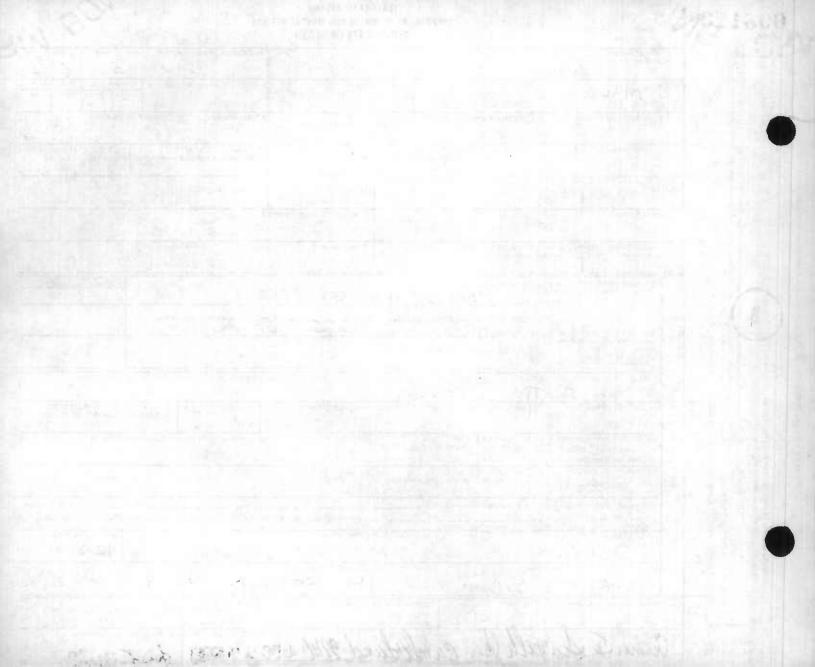
Hygie

Lawm Mem. Park

Lavale 250. DATE REC'D. BY REGISTRAR 256. REGISTRAR'S SIGNATURE

S00710 1 2011 Pantalline see a company (10/0) 50 50 mm .ph. T. mayer different at annual to the UEG 9 895 John Barton House.

006110	1-	FOR STATE REGISTRAR		DEPARTA		EALTH AND MENTAL HYGI ICATE OF DEATH	REG. NO		1	
ay be sage 3 death		CEASED NAME FIRS	THONY	MIDDLE		LA4		MONTH DAY	YEAR 5	26. HOUR 6 35 AM
Page 4 ma rector, pa irs after d	3 SE	MALE		white		6-21-1907 YEAR	4 AGÉ (IN YEARS LAST BIRT 78	YRS.	UNDER I YEAR	IF UNDER 24 HRS
ir deetin. I uneral di in 72 hou	C	RTHPLACE (STATE OR FOREIGN DUNTRY) MD TY OR TOWN OF DEATH	U	USA		NEVER MARRIED DO DINORCED	Allegany		MD.	
hours after in by the filed with	and the same	Frostburg	LE NOT IN SUCH FACILITY. GIVE STREE F TOSTOUTG VII		ADDRESS) Lage Nursing HOme		126 USUAL OCCUPATION (TIPE OF WORK FOR MOST OF WORKING LIFE) TETTED 126. KIND OF BI INDUSTRY TRAILTO			
thin 24 H	13a S	MD 13AS	Llegany	13c CITY OR TOW Cumber I	and		136. STREET ADDRESS 452 Penn	sylvani	.a Ave	nue/21502
cuted wi			/ Leo Cla				Elizabeth		LA:	51
an and c. Pages 1		VAS DECEASED EVER IN U YES, NO OR UNKNOWN) (IF YE NO	S. ARMED FORCES			Mrs. Mary C	ADDRE lay, Cumber	-		
ica sici ers ers atic even		IL CAUSE OF DEATH (En PART I. DEATH WAS C	ter only one couse AUSED BY EDIATE CAUSE (o)	CARDIO	NLA	ONARY ARR	EST		BETWEEN	ONSET AND DEATH
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 2120 IDING PHYSICIAN: The law require. The certificate be executed within 24 hour sitending physician. After this certificate has been signed by the stepling, sician and completely filled in by as the burial-transit permit. Then plea certificate has been signed by the stepling of the certificate has been signed by the stepling of the certificate has been signed by the certification of t		Canditians, if any, white gove rise to immedia cause (a), stating 11 underlying cause later PART 2 OTHER SIGNIFICATION (CANDITION)	th te DUE TO	O, OR AS A CONSEQUE O, OR AS A CONSEQUE CONTRIBUTING TO D	HTIC NCE OF	CARCINOMA O			IN PART 1	a:
The law re- The law re- e has been si e ermit. Then ne prior to shows any ii	CERTIFICATION	190 DATE OF OPERATION	DRTIC 196 COI	STEMOS NOITION FOR WHICH	OPERATIO	N WAS PERFORMED	200 AUTOPSY?		NG CAUSES	OF DEATH?
HYSICIAN: I physician. Is certificate rial-transit por final-transit por final-trans		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL EXAL	OF DEATH HOUR	E OF INJURY A.M. MONTH DA	Y YEAR	21c HOW INJURY OCCURR	YES NO A	YES [Y IN ITEM 18, PART		но 🗍
DING PH ttending c After this s the buria th and Me marked o	MEDICAL	214 INJURY OCCURRED WHILE NOT WHILE ON THE AT WORK		CE OF INJURY E, STREET, FACTORY, OFFICE, F	ARM, ETC)	211 LOCATION STREET	CITY OR TOW	'n	COUNTY	STATE
ATTENION and ECTOR: of Healinem 21 is 1		22a.1 certify that (I) (this saw the deceased all above, (I) (we) (did) (c	•		. 01	d that in (my) (aur) apinion d	, ta leath accurred on the do	te and haur o		that (I) (we) lost couses stated
TAL ON A the hosping RAL DIREC Betached for tate Dept. c		226. SIGNATURE HStell	in		~	ATTENDING PHYSICIAN	MEDICAL STAT	F IAN 🔲	22c. DATE	SIGNED 21.61
TO HOSPITAL OF ATTEN retained by the hospital or a TO FUNERAL DIRECTOR should be detached for use a with the State Dept. of Heal IMPORTANT: If Item 21 is		HARTIT	TYPE OR PRINT)			48 TARM TE		STBUR	a m	0, 21502
BP	(BURIAL, CREMATION, REMO SPECIFY) BUTIAL				ys Cemetery	23d Location Cumberla		egany	STATE MD
DHMH-16 25M (VRA 15, 4) 1/79	24 F	Limb J. Sc	arpelle	h- Cum	Perlu	nd Mu DEC	REC'D. BY REGISTRAR			URE



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND

			100
DEPARTMENT	OF HEALTH	AND MENTAL	HYGIENE
CFI	RTIFICATE	OF DEATH	

KIMENT OF HEALTH AND MENTAL HYGIENE	
CERTIFICATE OF DEATH	REG. NO.

		EASED NAME	FIRST		MIDDLE	LA	ST .	To DATE OF DEATH	MONTH	DAY	YEAR	26 HOU	IR
deoth	(TYPE	OR PRINT)	MARY		JANE	COL	EMAN	December 2	2, 198	5		7:2	25AM
D .	3. SEX	(4 RACE		5. DATE O	BIRTH	6 AGE (IN YEARS LAST E	IRTHDAY)	IF UNDER		IF UNDER	2411112
off	1	FEMALE		NIE	ROE	MONTH	LO/3/20 YEAR	65	YRS	MON1H5	DAYS	HOURS	M IN.
1 26	7a. BI	RTHPLACE (STATE O	RFOREIGN		WHAT COUNTRY?	8	NEVER MARRIED	9 BALTIMORE CITY		Y OF DE	ATH		
2		ARYLAND		U.S	. A.	WIDOWE		Allegany					MD.
TVI		TY OR TOWN OF DE	ATH	11. NAME OF	HOSPITAL, NURSIN	IG HOME O	ROTHER INSTITUTION	17a USUAL OCCUPA				BUSINE	SS OR
160	Cu	mberland		Memori	al Hospita	al		HOUSEKE	EPER		OME	PR.	TAVI
206		AL RESIDENCE (IF NO	13h COU		N GIVE RESIDENCE BEFORE		136 INSIDE CITY LIMITS?	13e STREET ADDRESS	7 7 IP COI	DF	7-10		
	M	ARYLAND	ALL	EGANY	FROSTBU		YES NO	83 BEAL			2	1532	2
×11		THER'S NAME		MIDDLE	LAST		15 MOTHER'S MAIDEN NAM	ME			LASI		
1/1/0	1	HARRY			CARTER	0.6135	MARY					SON	
117		VAS DECEASED EVE		MED FORCES?			17 INFORMANT	FROS	TBUR C	, M	D 2	1532	2
2 1/	NO		N.		220-03-7	7641	PAUL E. CO	LEMAN, 83	BEAI		Г.,		
ol.					er line for (a), (b , and	d (c)	1	1 115		8	APPROXI	MATE INTER	RVAL
emo		MARTI. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Advanced Meterstanic											
or r ofic	201	DUE TO, OR AS A CONSEQUENCE OF											
mno mno		Canditians, if any, which gave rise to immediate cause (a), stating the DUE TO, OR AS A CONSEQUENCE OF											
N													
to		underlying caus	e last.	(c)_									
ury. o	7	PART 2. OTHER SIG	SNIFICANT	CONDITIONS	ONTRIBUTING TO	DEATH BUT	NOT RELATED TO THE TERM	INAL DISEASE OR CO	NDITION G	IVEN IN P	ART No	1	
y in	CERTIFICATION	19a DATE OF OPER	ATION	Tipl CONU	DITION FOR WHICH	OBERATION	LAVAS DEDE ODATE	70g AUTOPSY?	1701 IE V	ES, WERE	EINIDIN	CC LICE	
M S D	FIG	198 DATE OF OPER	ATION	170 CON	DITION TOR WITHCH	OFERATION	WAS FERI ORMED		IN CERT	IFYING C		OF DEAT	TH?
ygier sho	ERT	71a. ACCIDENT WAS U	NDERLYING F	7 216 TIME	OF INJURY		21¢ HOW INJURY OCCURE	YES NO		YES TORI	PART 21	NO [
M 18		OR CONTRIBUTING	CAUSE OF DE	ATH HOUR	A.M. MONTH DA			TEN TENTON OF THE	,000	, , , , , , , , , , , , , , , , , , , ,	-1111 67		
Went r He	MEDICAL	(IF EITHER NOTIFY ME			P.M. E OF INJURY	19	711 LOCATION						
ed o	ME	WHILE NOT	VHILE [TREET, FACTORY, OFFICE, F	ARM, ETC.)	STREET	CHYOR	IOWN	COL	YTM	5	TATE
nork		AT WORK AT W		tat) attanded (the deceased fram_		19	to		, 19		L - A - 13 - 6	
f He		saw the deced obave, (1) (we)					d that in (my) (aur) apinion		date and hi				
ed to		obave, (I) (we)	(did) (did no	t) view the bad	y ofter death.		EGREE			-	DATE	GGNED	-
re De			2	Tur	-	W		MEDICAL ST DIRECTOR PHYS	AFF		12/	2/	85
ANI		22d. PHYSICIAN'S	NAME (TYPE	DR I RINT)				rial Hospit		dica	1 81	dg.	
should be d		Dr. Qama	r Zama	an				erland, MD				-0.	
4 3 3	73a F	URIAL CREMATION	I REMOVAL	73h DATE	173, N	NAME OF CE	METERY OR CREMATORY						

BP.

DHMH - 16 60M 7/B4 (VRA 15, 4)

STATE MD

FROSTBURG MEM PARK F
WASHIN ST. 125 DATE RECO.
FROSTBURG

TIPERIORE LORDER NA THE CALL FRANCISCO . AND LOS

- STATE REGISTRAR REG. NO 352138 I. DECEASED NAME 26 HOUP DATE KNOWN MONTH (TYPE OR PRINT) ESTI-OUR FILES. N 72 HOURS DEATH MATED MARY LOU 4 RACE 6. AGE (IN YEARS | IF UNDER) 3. SEX 5 DATE OF BIRTH IF UNDER 24 HRS 2c. DATE FUNERAL DIREC LAST BIRTHDAY PRONOUNCED WHITE 4/2/20 DEAD TO BIRTHPLACE (STATE OR 7b. CITIZEN OF WHAT COUNTRY? 9. BALTIMORE CITY OR COUNTY OF DEATH MARRIED NEVER MARRIED FOREIGN COUNTRY) PENNSYLVANIA U.S.A. X WIDOWED _ DIVORCED ALLEGANY II. NAME OF HOSPITAL NURSING HOME, OR OTHER INSTITUTION 120 USUAL OCCUPATION (TYPE OF WORK 126 KIND OF BUSINESS OR INDUSTRY HOUSEWIFE FROSTBURG OWN_HOME 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS HONEYSUCKLE 100 4 FATHER'S NAME IS MOTHER'S MAIDEN NAME MIDDLE LAST MIDDLE FIRST GRACE GLADYS SMITH FROSTBURG. 60 WAS DECEASED EVER IN U.S. ARMED FORCES? 16h SOCIAL SECURITY NO 17. INFORMANT NO OR UNKNOWN) N A WAR OR DATES) 177-26-5896 MINNICK. RT. 2. BOX APPROXIMATE INTERVAL CAUSE OF DEATH (Enter only ane cause per line far (a), (b), and (c). BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY: ARTERIOSCLEROTIC CARDIOVASCULAR IMMEDIATE CAUSE (a)_ DUE TO, OR AS A CONSEQUENCE OF Canditians, if any, which gave rise to immediate cause (a) stating the under-DUE TO, OR AS A CONSEQUENCE OF lying cause last. DIVISION OF VITAL RECORDS PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 In CERTIFICATION 19g. DATE OF OPERATION 196. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20 AUTOPSY? YES NO EXECUTE THE CERTIFICATE, WRITING THE WOR PAGE 4 SHOULD BE FORWARDED TO THE CI TO FUNERAL DIRECTOR, PAGE 3 SHOULD BE AFIER DEATH, WITH THE STATE DEPARTMENT BAILIMORE, MARYLAND, 21201 PRIQR-10 BU 210 EXTERNAL CAUSE WAS 2Th. TIME OF INJURY 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) HOUR A.M. MONTH DAY YEAR UNDERLYING OR CONTRIBUTING CAUSE OF DEATH The PLACE OF INJURY (AT HOME, 21d INJURY OCCURRED 21f. LOCATION STREET, FACTORY, FARM, ETC.) STREET CITY OR TOWN COUNTY WHILE AT WORK 22a I certify that I took charge of the remains described above, held an Autopsy Inspection and in my opinion Natural causes X Hamicide Undetermined manner death resulted fram: 5uicide TITLE (SPECIFY) 12/5/85 SIGNATURE. EXAMINER'S NAME Francisco Reves ADDRESS 900 Seton Dr. Cumberland TYPE OR PRINT 230 BURIAL, CREMATION, REMOVAL 236 DATE 23d. LOCATION FROSTBURG MEM. 07/84 25M **DHMH - 17** (VR A15 ME (5))

STATE OF MARYLAND

180 De Carlindial Maria Com 18030

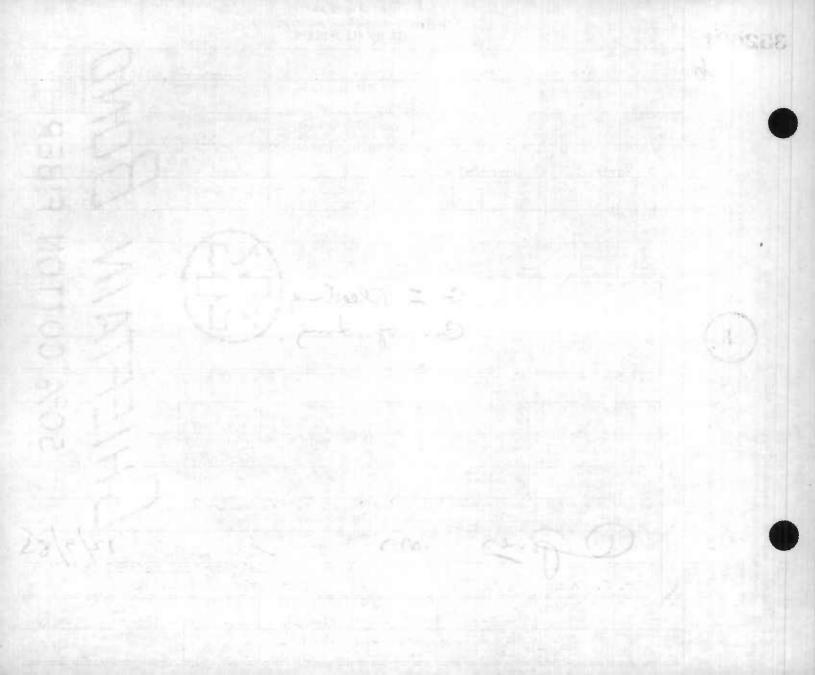
FOR STATE REGISTRAR 352001

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

	REOISTRAN				REG. NO.								
	DECEASED NAME FIRST TYPE OR PRINT)	WIDDLE	L.	LAST	26 DATE OF DEATH M	ONTH DAY YEAR	26 HOUR 3:10						
L	ALFRED	JOSEPH		MER, SR.	December	9, 1985	P M						
3.	SEX 4.	RACE	5. DATE C		6. AGE (IN YEARS LAST BIRTH	MONTHS DAYS	HOURS MIN						
	Male	White	June	11, 1933	52	YRS.							
70	BIRTHPLACE (STATE OR FOREIGN 76	CITIZEN OF WHAT COUN	TRY? 8 MARRIE	D KNEVER MARRIED	9. BALTIMORE CITY OR	COUNTY OF DEATH							
	Virginia	U.S.A.	WIDOWE	ED DIVORCED	□ Allega		MD.						
10	CITY OR TOWN OF DEATH	. NAME OF HOSPITAL, NU (IF NOT IN SUCH FACILITY, GIVE !		OR OTHER INSTITUTION	12a. USUAL OCCUPATIO	N 12b. KIND C WORKING LIFE) INDUSTRY	F BUSINESS OR						
1	Cumberland	Memorial Ho	spital		Mechanic-We	stern Maryl	and R.R.						
113	SUAL RESIDENCE (IF NURSING HOME OR OT 30. STATE 136 COUNTY		BEFORE ADMISSION)	1 13d. INSIDE CITY LIMITS?	13e STREET ADDRESS /	ZIP CODE	1999						
	West Va. Miner	cal Ridge	elev	YES NO	117 Main	Street / 26	753						
7	FATHER'S NAME FIRST MIC	DDLE LAST	ī	15 MOTHER'S MAIDEN N	NAME	LAS	ıt						
1	Emil !	3. Con	ner	Mary		Ros	s						
16	WAS DECEASED EVER IN U.S. ARME		SECURITY NO.	17 INFORMANT	ADDRES	S							
L		235-52	2-5023	Helen Comer	· - Address sa		bove.						
Г	18 CAUSE OF DEATH (Enter only		ol, and ich	20 1		APPROX BETWEEN	MATE INTERVAL ONSET AND DEATH						
П	PART I. DEATH WAS CAUSED I	1 American	-7 1	fleeding									
П		DUE TO, OR AS A CONS	EQUENCE OF	1									
	Canditions, if any, which	(1b) (b)	- 04	dong	Pi (g								
1	gove rise to immediate cause (a), stating the DUE TO, OR AS A CONSEQUENCE OF												
н	underlying cause lost (c)												
Ι,		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110											
18	190. DATE OF OPERATION 210. ACCIDENT WAS UNDERLYING												
1	190. DATE OF OPERATION	196 CONDITION FOR W	HICH OPERATIO	ON WAS PERFORMED		206 IF YES, WERE FINDING CAUSES	ING CAUSES OF DEATH?						
3 8				10.	YES NO NO	YES	NO 🗆						
	OR CONTRIBUTING CALLER OF DEATH	116. TIME OF INJURY HOUR A.M. MONTH	DAY YEAR	716. HOW INJURY OCCI	URRED (ENTER NATURE OF INJURY	IN ITEM 18 PART OR PART ?)	1.00						
1	(IF EITHER NOTIFY MEDICAL EXAMINER)	P.M.	19										
15	(IF EITHER NOTIFY MEDICAL EXAMINER) 21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OF	FFICE, FARM ETC)	211. LOCATION STREET	CITY OR TOW	N COUNTY	STATE						
1	AT WORK NOT WHILE			100									
1		27a 1 certify that (I) (this hospital) ottended the deceased from 1-30 , 19 85 , to 12-7 , 19 85 , that (I) (we) lost											
1	obaye, (II (we) (did) (did not)	object (The idid idid not view the body ofter death.											
1	226 SIGNATURE	nes	MI	DEGREE	MEDICAL STAFF	22c, DATE	9 GNED ON						
1			PHYSICIAN	DIRECTOR PHYSICIAN									
	22d. PHYSICIAN'S NAME (T			270 ADDRESS Memorial Hospital medical Building									
1	Dr. Q. Zaman				mberland, MD	21302							
	(SPECIEV)	23b. DATE		EMETERY OR CREMATOR	CITY OR TOWN	COUNTY	STATE						
	Burial	12-12-85	Davis M	emorial Cem.		-Allegany C							
24	FUNERAL DIRECTOR George 202 Greene Street	-Upchurch FUr	neral Ho	me, P.A. 756 D	ATE REC'D. BY REGISTRAR	IN REGISTRAR'S SIGNAT	URE notable						
	ZUZ Greene Street	-cumberland,	MD. ZI	.302	1, 10 1985	The same of the sa							

DHMH - 16 60M 7/84 (VRA 15, 4)



STATE OF	MARYLAND
----------	----------

03	1/	OR STATE REGISTRAR			DEPA		ALTH AND MENTAL H	YGIENE				
	DE	EASED NAME	FIRST		MIDDLE	LA	ST	2a DATE OF	REG. NO.	ONTH DA	AY YEAR	2b. HOUR
W/	(1795	J	ohn		E.	Cr	ites			2 10	0 85	9:50
BH	3.5E)		4	RACE		5 DATE O	BIRTH	6 AGE INY	EARS LAST BIRTHE	(YAY)	F UNDER I YEAR	IF UNDER 24 HRS
	M	ale	100	White		May	3. 1903	82		YRS	ONTHS DATS	MOURS MIN
	7e. 81	ETHPLACE THATE OR FO	OREIGN 71	CITIZEN OF	WHAT COUNT		□ NEVER MARRIED X		RE CITY OR		OF DEATH	
1	V	. Va.		USA		WIDOWE	DIVORCED [n any		MI	
0		TY OR TOWN OF DEA			HOSPITAL, NUE		OTHER INSTITUTION		Allegany 12a USUAL OCCUPATION 12b KIND OF E			F BUSINESS O
		umberland		Lions	Manor	Nursing	Home		inist		Rail	Road
7	USU/	AL RESIDENCE IN NURSI	136 COUNT	Υ	13t. CITY OR T		13d INSIDE CITY LIMITS?	13e.STREET	ADDRESS / Z	IP CODE		20
4			Alle	Jany	Cumber	cland	YES 🕅 NO 🗌	424	Colu	mbia	St.	21502
/	14. FA	THER'S NAME	M	DDLE	LAST	150	15. MOTHER'S MAIDEN I	NAME	MIDDLE		LAS	т
		Allen			Crit		Rosa		F.		Ze:	rk
		(AS DECEASED EVER I		ED FORCES? WAR OR DATES)	166 SOCIALS		17 INFORMANT		ADDRESS			
		No			705-12	2354	Eleanor	Crites	01d	town	MD	
	18	18 CAUSE OF DEATH PART I. DEATH W.	A Enter anly	ane cause pe	line far (a), (b)	and ic	0	10	1. 0		BETWEEN	MATE INTERVAL ONSET AND DEATH
34	13		IMMEDIATE		Meta	Static	Concino	ma of	The &	mg	>	
or re office				DUE TO, C	R AS A CONSE	OUENCE OF					1000	
	100	Canditians, if any,		((b)_				V		1		
Н	1	gave rise to imm cause (a), stating	g the	DUE TO, C	R AS A CONSE	OUENCE OF						
		underlying cause	last.	(c)_								
d	7	PART 2 OTHER SIGN	IFICANT CO	NDITIONS C	ONTRIBUTING	TO DEATH BUT	NOT RELATED TO THE TE	RMINAL DISEAS	OR CONDIT	ION GIVE	N IN PART 110	1
4	TION	C.U.) -		ueve						4757	
	IFICAT	190 DATE OF OPERAT	ION	196 COND	ITION FOR WH	ICH OPERATION	WAS PERFORMED	20a AUTO			WERE FINDIN	
	CERTIF							YES 🗌	NO	YES		NO 🗌
4	144	210. ACCIDENT WAS UND		21b. TIME								
1	0	OR CONTRIBUTING C	AUSE OF DEATH	HOUR A	.M. MONTH	DAY YEAR	TIT HOW INJURY OCC	URRED (ENTER NA	TURE OF INJURY I	N ITEM 18 PAR	RT OR PART 2)	
	4	OR CONTRIBUTING C	ALEXAMINER)	Р	.M.	DAY YEAR		URRED (ENTER NA	TURE OF INJURY I	N ITEM 18 PAR	RT I OR PART 2)	
	4	(IF EITHER NOTIFY MEDIC 21d INJURY OCCURR	ED	21e PLACE	.M. OF INJURY	19	211 LOCATION STREET	URRED (ENTERNA	TURE OF INJURY I		COUNTY	STATE
	MEDICAL C	(IF EITHER NOTIFY MEDIC	ED	21e PLACE	.M.	19	211 LOCATION	URRED (ENTER NA				STATE
	4	(IF EITHER NOTIFY MEDIC 21d INJURY OCCURR NOT WHI AT WOR 220 I certify that (I)	ED (this haspita	21e PLACE (AT HOME SI	.M. OF INJURY REET, FACTORY, OFF	19 CE, FARM, ETC)	211 LOCATION	URRED (ENTER NA				STATE
	4	(IF EITHER NOTIFY MEDIC 21d INJURY OCCURR NOTIFY MEDIC 12d INJURY OCCURR NOTIFY MEDIC NOTIFY ME	ALEXAMINER) TED ILE (this haspital adults an	21e PLACE (AT HOME SI	.M. OF INJURY REET, FACTORY, OFF	19 CE, FARM, ETC.)	211 LOCATION	, ta	CITY OR TOWN	, 1	COUNTY	that (I) (we) la
	4	(IF EITHER NOTIFY MEDIC 21d INJURY OCCURR NOT WHI AT WOR 220 I certify that (I)	ALEXAMINER) TED ILE (this haspital adults an	21e PLACE (AT HOME SI	.M. OF INJURY REET, FACTORY, OFF	19 CE, FARM, ETC) m 70 - 15 9 - 25 , and	211 LOCATION STREET	, ta	CITY OR TOWN	, 1	COUNTY	that (I) (we) la
	4	(IF EITHER NOTIFY MEDIC 21d INJURY OCCURR NOT WHI AT WOR 22a I certify that (I) the decease abave, (I) (we) (d)	ALEXAMINER) TED ILE (this haspital adults an	21e PLACE (AT HOME SI	.M. OF INJURY REET, FACTORY, OFF	19 CE, FARM, ETC) m 70 - 15 9 - 25 , and	211 LOCATION STREET 19 I that in (my) (aur) apini EGREE ATTENDING	an death occurre	CITY OR TOWN 3 - 10 d an the date STAFF	, 1' and haur	COUNTY and fram the	that (I) (we) la
	4	(IF EITHER NOTIFY MEDIC 21d INJURY OCCURR NOT WHI AT WOR 22a I certify that (I) the decease abave, (I) (we) (d)	ALEXAMINER) BLE (this haspita d alive an _ id) (did nat)	P P P P P P P P P P P P P P P P P P P	.M. OF INJURY REET, FACTORY, OFF	19 CE, FARM, ETC) m 70 - 15 9 - 25 , and	211 LOCATION STREET 19 I that in (my) (aur) apini EGREE ATTENDING	, ta an death occurre	CITY OR TOWN 3 - 10 d an the date STAFF	, 1' and haur	COUNTY and fram the	that (I) (we) la causes stated
	4	(IF EITHER NOTIFY MEDIC 21d INJURY OCCURR NOT WHI AT WOR 22d I certify that (I) the decease abave, (I) (we) (d 22b. SIGNATURE 22d PHYSICIAN'S NA	ALEXAMINER) THE CONTROL OF THE CONT	PRINT	.M. OF INJURY REET, FACTORY, OFF The deceased Ira y after death	19 CE, FARM, ETC) m 70 - 15 9 - 25 , and	211 LOCATION STREET 19 1 that in (my) (aur) apinin EGREE ATTENDING PHYSICIAN 22e ADDRESS	, ta	CITY OR TOWN 3 - 10 d an the dote STAFF PHYSICIA	and haur	county 98 and fram the country 72c. DATE	that (I) (we) la causes stated SIGNED
	MEDICAL	(IF EITHER NOTIFY MEDIC 21d INJURY OCCURR NOTIFY MEDIC 22a I certify that (I) who decease abave, (I) (we) (d) 27b. SIGNATURE	ALEXAMINER) ED OILE	P P P P P P P P P P P P P P P P P P P	.M. OF INJURY REET, FACTORY, OFF	19 CE, FARM, ETC) m 10 13 9 . and	211 LOCATION STREET , 19 I that in (my) (aur) apinio EGREE ATTENDING PHYSICIAN 22e ADDRESS LMNH Sete	medical Directors	STAFF PHYSICIA Cumb	and haur	county 98 and fram the country 72c. DATE	that (I) (we) la causes stated SIGNED
1	WEDICAL MEDICAL	(IF EITHER NOTIFY MEDIC 21d INJURY OCCURR NOT WHI AT WOR 220 I certify that (I) the decease abave, (I) (we) (d 22b. SIGNATURE 22d PHYSICIAN'S NA V. A. Ra:	ALEXAMINER) ED OILE	PRINT) PRINT PAGE (AT HOME SI AT HOME SI	.M. OF INJURY REET, FACTORY, OFF. The deceased Ira rafter death, 11	19 CE, FARM, ETC) m 10 - 13 9 . and	211 LOCATION STREET 19 1 that in (my) (aur) apinin EGREE ATTENDING PHYSICIAN 22e ADDRESS	medical Directors medical Directors medical Directors medical Directors	Cumb	and haur	and from the 22t. DATE	that (I) (we) la causes stated SIGNED

		82	3, 1903	Ya .	White	olas
		1.0			USA	.sv .W
Rail Foad	inist).ach				Cumberland
St. 21502	Columbia	424	9 ² 00, 000.	Cumberland	Allegany	. C
alue"	• দু		530%	Urites		Allen
CM,	Oldtown	Crites	Eleanor			01

Lurial

Dec. 13, 1985 Sunset Menorial P. Cumberland Allegany AD William G. Might Cumberland, MD

death o

10 HOSPITAL OR ATTENDING PHYSICIAN: The retained by the hospital ar attending physician.

BP.

345161

24 hours ofter deoth. Poge

ond completely

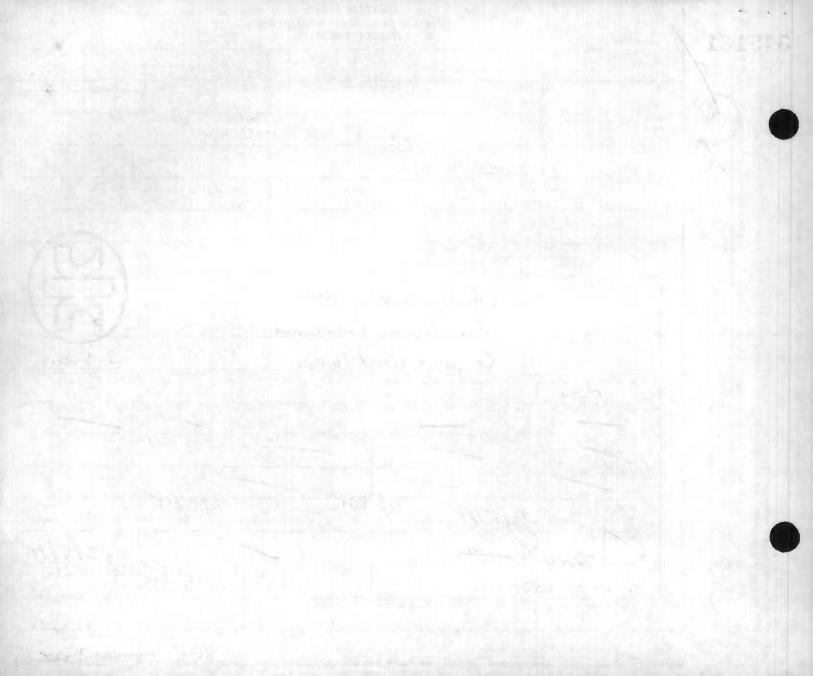
TO FUNERAL DIRECTOR, After this certificate has been signed by the attending physician and cashould be detached for use as the burial-transit permit. Then please remove corbompopers. Pages with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

- STATE REGIST	RAR				CERTIF	ICATE OF DEATH		REG. NO.					
1. DECEASED N	NAME	FIRST				LAST .	2 a	DATE OF DEATH MONTH	DAY YEAR	26 HOUR			
(ME ON PRINTY	1	RENE	(CECELIA	C	CRITZMAN		cember 5, 198	35	2:03P w			
3 SEX			4. RACE		5. DATE C		6. A	GE (IN YEARS LAST BIRTHDAY)	MONTHS DATS	IF UNDER 24 HRS			
Femal	е		White			ruary 28 1	905	80 _{YR}		HOURS MIN.			
G. BIRTHPLAC	E (STATE OR FO	REIGN	76 CITIZEN OF	WHAT COUNTRY?	8	D NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryl	and	9		USA	WIDOWE		A.	11egany		MD.			
10 CITY OR TO	WN OF DEAT	Н		HOSPITAL, NURSIN		OR OTHER INSTITUTION	ITION 120 USUAL OCCUPATION 12b KIND OF BUSINE						
Cumber:	land			al Hospit			Beautician Hair Salo						
USUAL RESIDE		IG HOME OR		GIVE RESIDENCE BEFORE		13d INSIDE CITY LIMITS?	113.5	STREET ADDRESS / ZIP CO	Cumberl	and, Md.			
Maryl	and	Alle	gany	Cumber	-	YES NO	R	t. 3 Thurm	el Driv	e21502			
14 FATHER'S N	IAME IRST		MIDDLE	LAST		15 MOTHER'S MAIDEN N	NAME	MIDDLE	IA ⁴	7			
Da	vid		H.	Coffma	n	Mary			Gu				
160 WAS DECI			MED FORCES?	166 SOCIAL SECU	RITY NO.	17 INFORMANT	-	ADDRESS	C VA	1733			
No	JAKAOWA)	(ir 123, 014)	- WAR ON DATES	214-32-3	278	Wanda Me	110	n-Cumberla	nd, Md.				
18 CAU	SE OF DEATH	Enter an	y ane cause per	line far (o), (b), and	(c	0			APPROX BETWEEN	MATE INTERVAL ONSET AND DEATH			
PART			E CAUSE (a)	Andropal	MONT	on accept			-				
			DUE TO, O	BAS A CONSEQUE	NCE OF	0			2				
	ans, if any,		((b) 1	Spondros		Caranoni	A	Mark In British					
couse	rise to imme (a), stating	the	DUE TO, QI	R AS A CONSEQUE	NCE OF	. 0 . 1							
underly	ring cause	last.	(c) C	orgestive	Neg	ut failure			2-5	days			
PART 2	- 1		ONDITIONS CO	NIRBUTING TO D	EATH BUT	NOT RELATED TO THE TE	RMINAL	DISEASE OR CONDITION	GIVEN IN PART 1	0			
ZIE ACC		ne											
Ma.OATE	OF OPERATI	ON	19L CONDI	TION FOR WHICH	OFFRATIO	N WAS PERFORMED	26		YES, WERE FINDIP RTIFYING CAUSES				
E		ALCO STORM	AD 18018 A			In	14	ES O NOT	YES []	NO []			
	DENT WAS UNDE		HOUR A		Y YEAR	THE HOW INJURY OCCU	URRED	ENTER HATURE OF HOURS IN TEM	IS FAST CONTACT TO				
S IF UM	R. HOTHY HEDICA	LEXAMINE	P.I		19								
SHE INJ	IRY OCCURRS	-	THE PLACE OF	OF INJURY	RM. ETC. Y	ZH LOCATION		CITY DE 10WW	COUNTY	55476			
w) mose;						06-		11					
	RESIDENCE DE MONTONIA		oll oftended the	deceased from_	111	19		10 (45/1)		that (I) (we) last			
abo		d idid not	viger the body	offer death.	11.00		on death	occurred on the date and	CHARLEST STREET	Contract Contract			
774.510	1	-		40	1	DEGREE ATTENDING	1 144	HOICAL STAFF	IN DATE	SIGNED			
	SICIAN'S MA	kalaa	200			PHYSICIAN	DIR	ECTOR PHYSICIAN	1/2	15/13			
	Howar	San Williams	1001174			17* ADDRESS Mer	mori mber	al Hospital land, MD 215	Medical 02	Bldg.			
23s. BURSAL, C	REMATION, R	EMOVAL	73h. DATE	7h. N	AME OF C	EMETERY OR CREMATORY	Y 1	M LOCATION	7000000	200			
11227	urial		12-7-	85 Zi	on M	emorial Pa	rk	Cumberalnd	Allega	nv Md.			
24 FUNERAL D	IRECTOR	Cumb	erland	, Maryl		21502 250 D	ATE REC	D. BY REGISTRAR 256. REC					
Leasur	e-Ste	in I	nc. 23	0 Balti	more	Ave.	リヒじ	9 1985	- herdoon	Alanders			

DHMH - 16 60M 7/84 (VRA 15, 4)



		CHURCH FUNERAL H	OME STATE OF MARYLAND	5 5 5 2	305
8	1 - STATE 202 GREEN		RTMENT OF HEALTH AND MENT		
/ 344083	REGISTRAR CUMBERL		CERTIFICATE OF DEAT	REG. NO.	
1	DECEASED NAME FIRST	MIDDLE	LAST	20. DATE OF DEATH MONTH	DAY YEAR 26 HOUR
1 100 7	WILLI		DAILEY	DECEMBER 4, 198	
1 1 1	130	4 RACE		6. AGE (IN YEARS LAST BIRTHDAY)	MONTHS DAYS HOURS MIN.
1 11 //	Male	White	February 6, 19		
The telle	70. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	76. CITIZEN OF WHAT COUNTR	MARRIED A NEVER MARRI		
1104	WEST Virginia	U.S.A.	WIDOWED DIVORCE		12b. KIND OF BUSINESS OR
-(# H &x		(IF NOT IN SUCH FACILITY, GIVE STR SACRED HEART	EET ADDRESS)	(TYPE OF WORK FOR MOST OF WORKING LIF	& Paul Cath, C
		E OR OTHER INSTITUTION GIVE RESIDENCE BEF	ORE ADMISSION)		
8 2 9 9 7 N		legany Cumber			
和 非 統 第一	14 FATHER'S NAME	MIDDLE LAST	15. MOTHER'S MAIL	DEN NAME	C / 21302
W 1 11/1/	Earl	Daile	y Lucil		Edenhart
# 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	160 WAS DECEASED EVER IN U.S.	ARMED FORCES? 166 SOCIAL SE	CURITY NO. 17 INFORMANT	ADDRESS	
TIMO	Yes W	.W.II 214 07	5136 Josephone	Dailey-ADdress same	
The second of th	18 CAUSE OF DEATH (Enter	only one cause per line to (p.), (b).	and ic	- 1	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ST.		DIATE CAUSE (a)	Mr My	(MA)	1-7
NOT at the state of the state o		DUE TO, OR AS A CONSEC	DUENCE OF	entra	
MES de	Canditions, if ony, which gove rise to immediate	(b)	7,	Oute	
W d de d	cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEC	DUENCE OF		
201 pried pried y, or	PART 2 OTHER SIGNIFICAN	NT CONDIFIONS CONTRIBUTING T	O DEATH BUT NOT RELATED TO TH	HE TERMINAL DISEASE OR CONDITION GIV	EN IN PART 1(a
RDS	NOI	1) mules	· CA	lung	
DECC BECC	190 DATE OF OPERATION	196 CONDITION FOR WHI	CH PPERATION WAS PERFORMED		, WERE FINDINGS USED YING CAUSES OF DEATH?
VITAL N The N The Control to Hygene	#1 M				S NO [
	210. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF		DAY YEAR	OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 P	ART I OR PART 2)
NG PHYSICIA otherding of the this certif on the burnship in and Mental	(IF EITHER NOTIFY MEDICAL EXAMI	P.M. 21e. PLACE OF INJURY	19 211 LOCATION		
MSIO Herry H	WHILE O NOT WHILE O	(AT HOME STREET FACTORY, OFFICE		CITY OR TOWN	COUNTY STATE
Den O o o o o o o o o o o o o o o o o o o	AT WORK	aspital) attended the deceased from	11/20	8 12/4	10 that (I) (wa) last
THEN TO SEE THE SEE TH	saw the deceased alive	an 12/4 19		opinion death occurred on the date and have	r and from the causes stated
F P P P P P P P P P P P P P P P P P P P	226. SIGNATURE	nat) view the bady after death	DEGREE		22c DATE SIGNED
4 4111		strine 1	M ATTENI	DING MEDICAL STAFF	112/4/6
The State of the S	22d. PHYSICIAN'S NAME (H	PE OR PRINT	22e ADDRESS		1 / 8
Apple of the standard of the s	RENATO ESPIN	IA MD	907 SETC	ON DRIVE, CUMBERLAND,	MD 21602
51 50136	23a BURIAL, CREMATION, REMOV		NAME OF CEMETERY OR CREMA	CITY OR TOWN	COUNTY STATE
BP	Burial	12-7-85 S	S. Peter & Paul		
DHMH - 16 60M 7/84	24 FUNERAL DIRECTOR Geor	ge-Upchurch Fune	ral Home, P.A.	250. DATE REC'D. BY REGISTRAR 256. REGIST	RAR'S SIGNATURE
(VRA 15, 4)	202 Greene Stre	et, Cumberland,	Md. 21502	UEC 6 1985	wardon Abadan

BIRDES

onit-n

YT TIOO Y MESSICIA

CUSAS ENVENTARISMENTO CALLA CONTRACTOR

PELATE S DA M

21562

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO

BOALS FUNERAL HOME

1 - STATE 111 CHURCH STREET

REGISTRAR WESTERNPORT. MD

364061

(VRA 15, 4)

CECHRER 19, 1985 1:008 ALLECNIM CONTY	9 1.15 x	21562 DAN SCI	FUNDER STREET THE PORT, THE SALES STREET WILLES SALES	oriui Britania Britania	lagnas
Shirts of the		2001 To 1/19	140 45		
			. Elt-		
in son estamout, i.d. 21562	no for est	2-38-6295			
	3-1-48				
SETO CETYE	N/G		ALT ALIA		
STATE OF STA					

20	
55	
c	
100	
므	
z	
æ	
3	
~	
_	
sa;	
4ď	
-	
æ	
-5	
ш	
翠	
寒	
v	
5	
穒	
ᆮ	
==	
軧	
-	
-41	
- 1	
-	
in	
7	
z	
o	
m	
w	
ш	
œ	
酝	
3	
3	
3	
0	
201 W	
0	
20	
5, 20	
DS, 20	
RDS, 20	
RDS, 20	
ORDS, 20	
CORDS, 20	
ORDS, 20	
RECORDS, 20	
RECORDS, 20	
CORDS, 20	
AL RECORDS, 20	
RECORDS, 20	
AL RECORDS, 20	
AL RECORDS, 20	
F VITAL RECORDS, 20	
AL RECORDS, 20	
F VITAL RECORDS, 20	
F VITAL RECORDS, 20	
F VITAL RECORDS, 20	
ION OF VITAL RECORDS, 20	
IN OF VITAL RECORDS, 20	
ION OF VITAL RECORDS, 20	
ION OF VITAL RECORDS, 20	
ION OF VITAL RECORDS, 20	
ION OF VITAL RECORDS, 20	
ION OF VITAL RECORDS, 20	
ION OF VITAL RECORDS, 20	
ION OF VITAL RECORDS, 20	

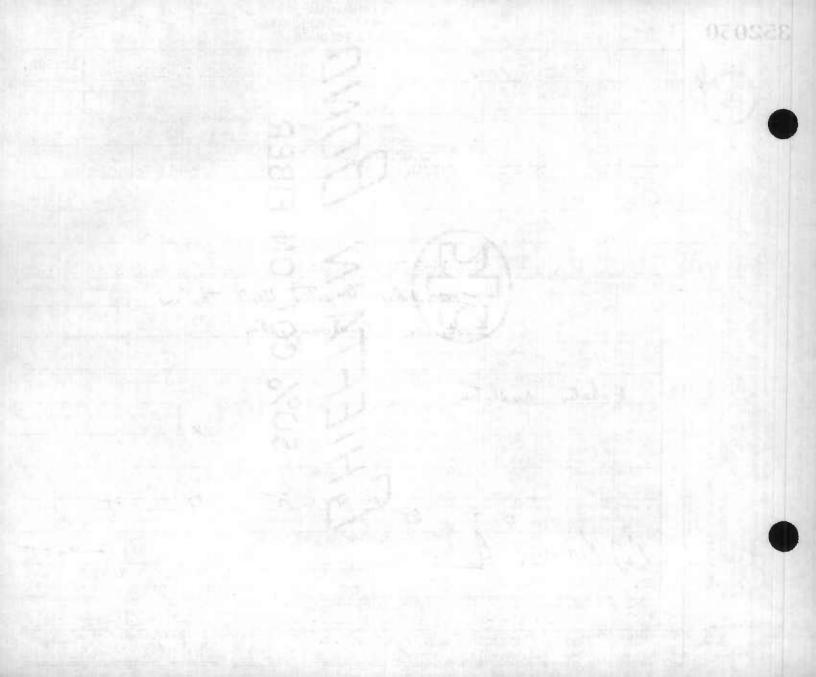
STATE OF MARYLAND

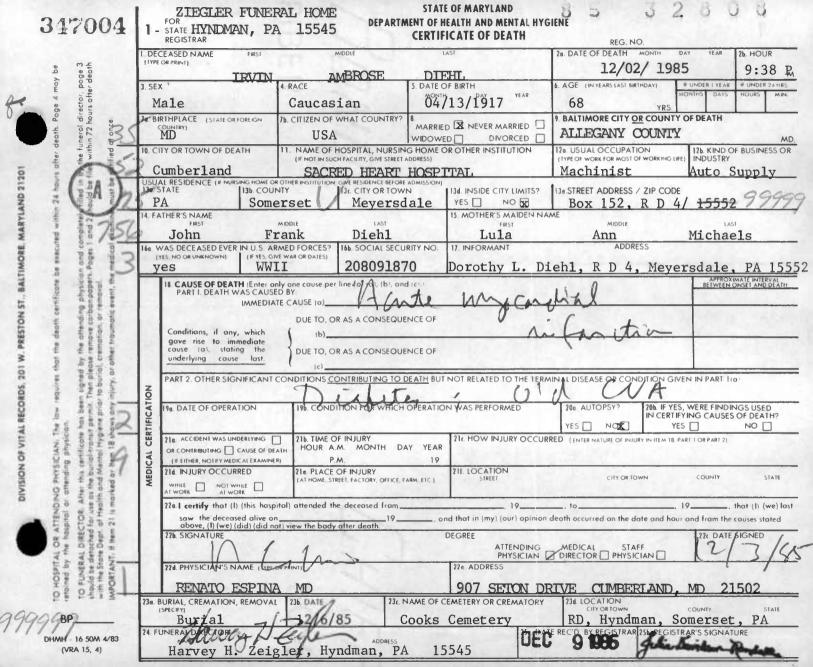
DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1	FOR STATE REGISTRAR		DEPARTA		EALTH AND MENTAL HYG ICATE OF DEATH	IENE REG. NO	0.				
	ECEASED NAME FIRST		MIDDLE	ı	AST	20 DATE OF DEATH		DAY YEAR	2h HOUR	~ .	
1141	PE OR PRINT) PEARI		Α.	DEL	BUSSO	DECEMBER 7	, 198	5	10:30	UA.	
3 SI	EX	4 RACE		5. DATE C		6 AGE (IN YEARS LAST BIR	THDAY)	IF UNDER I YEAR	IF UNDER 24		
Fe	emale	White	2	AUSUS	t 15.1918	67	YRS	MONTHS DAYS	HOURS	MIN.	
7a 8	SIRTHPLACE (STATE OR FOREIGN	76 CITIZEN OF	WHAT COUNTRY?	8.	D WEVER MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH					
Pe	ennsylvania	U.S.	Α.	WIDOWE		Allega	ny			MD.	
10.0	CITY OR TOWN OF DEATH		HOSPITAL, NURSIN		OR OTHER INSTITUTION	12a USUAL OCCUPATI		12b. KIND C	F BUSINES	SOR	
	MBERLAND	MEMORIA	L HOSPITA	L				han Shr	ine		
13a.	JAL RESIDENCE (IF NURSING HOME OF STATE 1336 COL	YINL	13c. CITY OR TOW	N	13d. INSIDE CITY LIMITS?	13e STREET ADDRESS A	zip code phart	Drive	/ 2150	02	
14. F	ATHER'S NAME	WIDDLE	LAST		15 MOTHER'S MAIDEN NA	ME MIDDLE					
	Thomas	P.	Anse	11	Malinda	MIDDLE		P	irl		
	WAS DECEASED EVER IN U.S. A	RMED FORCES?	166 SOCIAL SECU		17 INFORMANT	ADDRE	SS	1 KI B			
	(YES, NO OR UNKNOWN) (IF YES, C	GIVE WAR OR DATES)	171-14-5	831	Dominic Del	Busso - Add	ress	same as	#13.		
- 1	18 CAUSE OF DEATH (Enter of PART I. DEATH WAS CAUS	only one couse per SED BY: ATE CAUSE (o)	Trutas	1 0 0	angerting to	Lent Fail	Par	APPROX BETWEEN	MATE INTERVA ONSET AND DE	ATH	
CERTIFICATION	gove rise to immediate couse (a), stating the underlying couse last. PART 2 OTHER SIGNIFICANT Coulons PART 2 OTHER SIGNIFICANT PART 2 OTHER SIGNIFICANT PART 2 OTHER SIGNIFICANT	conditions co	Tu	DEATH BUT	NOT RELATED TO THE TERM	INAL DISEASE OR CON	20b. IF YES	EN IN PART 1: 5, WERE FINDIN	NGS USED	?	
] #						YES NO		5	NO 🗌		
	2 a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF D (IF EITHER NOTIFY MEDICAL EXAMIN	EATH HOUR A.	M. MONTH DA	AY YEAR	21c. HOW INJURY OCCUR	RED (ENTER NATURE OF INJU	RY IN ITEM 18 P	PART OR PART 2)			
MEDICAL	21d INJURY OCCURRED WHILE NOT WHILE AT WORK	21e PLACE	OF INJURY REET, FACTORY, OFFICE F	ARM ETC)	21f. LOCATION STREET	CITY OR TO	WN	COUNTY	STA	TE	
	220 I certify that (I) (this has saw the deceased alive a above, (I) (we) (djd) (did n			35.0	nd that in (my) (our) opinion	, to	ote and hou		that (1) (we causes state		
	10 Nav	ere, L			DEGREE ATTENDING PHYSICIAN	MEDICAL STAF	F IAN []	22c DATE	SIGNED - 8	3.5	
	DR. BARRERA	OR PRINT)			"MEMORIAL HO CUMBERLAND.		ICAL 215	BUILDIN	iG		
730	BURIAL, CREMATION, REMOVA	1 23h, DATE	236 1	NAME OF C	EMETERY OR CREMATORY	123d LOCATION	213	02			
B	urial	12-9-			wn Meml. GArd		Alleg	any-Mar	yland	/E	
24	FUNERAL DIRECTOR Georg	e-Upchur	ch Funera	al Hon	ne, P.A. 250 DAT	E REC'D. BY REGISTRAR					
2	02 Greene Stree	t-Cumber	land, Mar	ryland	1 21502 DE	C 1 6 1985	7			á.	

DHMH - 16 60M 7/84 (VRA 15, 4)

should be detached for use with the State Dept. of Hea MPORTANT: If hem 21 is



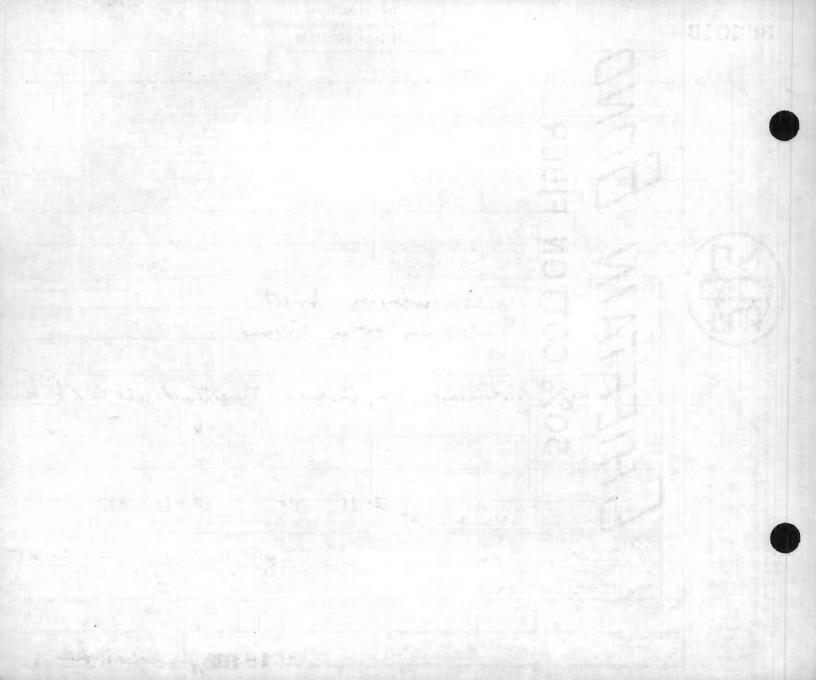


TANK TERRORITA SOURCEDE DICKER OF THE CONTROL OF THE LAND THE PER COUNT 107 SERVE DRIVE CURTERING, NO. 21502 DEC 9 THE Shirtmenton

STATE OF MARYLAND

1013	1 -	FOR STATE REGISTRAR	DEPART	MENT OF HEALTH AND MENTAL HY CERTIFICATE OF DEATH	GIENE REG. NO.					
		EASED NAME FIRST	WIDDLE	LAST	20. DATE OF DEATH MONTH DAY YEAR 26 HOUR					
er deoth	(14hF	EDMO	N YOUNG	DILL	December 12, 1985 9:25					
fter	3 SEX		4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 2-					
0 50		male	white	01-03-1909	76 _{YRS}					
12 ho		RTHPLACE (STATE OR FOREIGN OUNTRY) WV	76 CITIZEN OF WHAT COUNTRY USA	MARRIED NEVER MARRIED WIDOWED DIVORCED	BALTIMORE CITY OR COUNTY OF DEATH Allegany					
Coffeed with		TY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSI (IF NOT IN SUCH FACILITY, GIVE STREE Memorial Hosp		Tet. engineer railroad					
and be e	UsU,	AL RESIDENCE (IF NURSING HOME OF	OTHER INSTITUTION, GIVE RESIDENCE BEFO	RE ADMISSION) WN 113d INSIDE CITY LIMITS?	13e.STREET ADDRESS / ZIP CODE 22 Utah Avenue/21502					
000 C //	14. FA	THER'S NAME Ernest O.	MIDDLE LAST	15. MOTHER'S MAIDEN NAME						
loges 1		VAS DECEASED EVER IN U.S. AR		ADDRESS						
Pog		yes WW		-0687 Mrs. Margare	et A. Schaefer-Frederick, MD					
then please ren to burial, cremi njury, or other t	NOI	gove rise to immediate cause (a), stating the underlying cause last	DUE TO, OR AS A CONSEON		MINAL DISEASE OR CONDITION GIVEN IN PART 1:0 Travaiting all Cag ble					
permit. T	CERTIFICATION	190 DATE OF OPERATION	19b. CONDITION FOR WHIC	H OPERATION WAS PERFORMED	200 AUTOPSY? 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH YES NO YES NO					
of tronsit		210. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DE	HOUR A.M. MONTH	DAY YEAR	RRED (ENTER NATURE OF INJURY IN ITEM 18 PART OR PART 2)					
the bur	MEDICAL	21d INJURY OCCURRED WHILE NOT WHILE AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE	PARM ETC) 21f LOCATION STREET	CITY OR TOWN COUNTY STA					
S E T	-	22n L certify that (I) (this hash	ital) attended the deceased from	1985	, to, to, that (I) (we are and hour and from the causes state					
of Health		saw the deceased alive on abaye, (1) (we) (did) (did no	at) view the body after death.							
detached for use as tote Dept of Health (saw, the deceased olive on aboye, (I) (we) (did) (did no URE	at) view the body after death.	DEGREE ATTENDING PHYSICIAN	MEDICAL STAFF DIRECTOR PHYSICIAN 12-13-					
oold be detached for use os the the State Dept of Health NPORTANT: If hem 21 is mark		saw the deceased alive on abaye, (1) (we) (did) (did no URE	at) view the body after death.	DEGREE ATTENDING PHYSICIAN 726 ADDRESS Memor	MEDICAL STAFF					
od to de	23a £	saw the deceased alive an aboys. (I) (we) (did) (did no like) (we) (did) (did no like) (we) (did) (did no like) (did) (did no like) (did)	DR PRINTI D Barrera 23b. DATE 23c.	DEGREE ATTENDING PHYSICIAN 726 ADDRESS Memor	MEDICAL STAFF DIRECTOR PHYSICIAN 12-13- ial Hospital Medical Bldg. rland, MD 21502					

DHMH - 16 60M 7/84 (VRA 15, 4)



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1		FOR STATE			DEPART		CATA ON	MENTAL HYG	IENE		1			
-1		REGISTRAR LEASED NAME	FIRST		MIDDLE		AST	DUAIS.	20 DATE OF DE	REG. NO.	NIH DAT	YFAR	21 110110	
d		OR PRINT)			_			-	Za DATE OF DE	AIH MO		TEAR	2b HOUR	
51			SAMUE		reeman			JR	DECEMBE		1985	INDER : YEAR	6:10	AM
41	J: 5E)	Male		4 RACE Whi	+-	S. DATE C	DAY	4534	6 AGE (IN YEAR	LAST BIRTHO	MON	THS DAYS	HOURS /	MIN.
4	1. 00	RTHPLACE (STATE ORF				Sept	• 15,	1921	64		YRS			
16		OUNTRY	FOREIGN		WHAT COUNTRY	MARRIE	D NEVE	MARRIED -	9 BALTIMORE	_		PUEATH		
-	10 61	PA TY OR TOWN OF DEA	TU	USA	HOSPITAL, NURSI	WIDOWE	-	ONORCED	ALLEG				5 04 (CW 15 C)	MD.
2	1				ED"HEART			STITUTION	(TYPE OF WORK FO			126 KIND O INDUSTRY		
4		Cumberlar					LIAL		Manage	er		Auto	mobil	.e_
0	13e. S	AL RESIDENCE (IF NURS	136 COUN	TY	134 CITY OR TO		13d. INSIDE	CITY LIMITS?	13e.STREET ADD			, -		
1		aryland	All	egany	Corriga	nvil		NO S	P.0.	Box	236	/ 21	524	
1	14, FA	THER'S NAME		MIDDLE	LAST		15 MOTHE	R'S MAIDEN NA FIRST		IDDLE		LAS	r	
V		Samuel	F.		Dishons			Marie	1 11 11 11 11		Duc	kwor	th	
/		VAS DECEASED EVER	(IF YES GIVE	WAR OR DATES)	16b SOCIAL SEC		17 INFORA			ADDRESS				
		Yes	MM	II	215–12-	-2598	Mrs.	Sandr	a Rober	rtsor	n-Lea	_		<u>1010</u>
31	3	18 CAUSE OF DEATH PART I. DEATH W	H Enter on	y one couse per	line for (a), (b), a	nd is 1	5	. +		• 0			MATE INTERVA	ATH
2		17,000		E CAUSE (o)	HU	ule	1720	siral	our To	ulee	N	2	WE.	5
2.		773		DUE TO, O	R AS A CONSED	JENCE OF	(3	0 11	to D	0		1	N 111	
		Conditions, if ony, gove rise to imm		(b)_	(4)	ron	16 U	myrell	chur !	ulm	sences	1	o ge	10/00
		couse (a), statin	ig the	DUE TO, O	R AS A CONSEQU	JENCE OF	0	esla	al		0		0	
3	4			((c)										_
	z	PART 2 OTHER SIGN	VIFICANT C	onditions <u>co</u>	ONTRIBUTING TO	DEATH BUT	NOT RELATI	D TO THE TERM	AINAL DISEASE O	RCONDIT	ION GIVEN	IN PART 110	,	
-	ATIO	90 DATE OF OPERAL	TION	19h COND	ITION FOR WHICH	HOPERATIO	NI WAS DEDE	OPMED	20e AUTOPS	v2 2	Nh IE VES W	VERE FINDIN	ICS HSED	
4	FIC	THE DATE OF OPERA	11014	170. COND	ITON TOR WITH	OPERATIO	WASPERI	OKMED		11	CERTIFYIN	NG CAUSES	OF DEATH?	>
1	CERT	71a. ACCIDENT WAS UND	DERLYING T	21b. TIME O	F IN HIRY		Tale HOW	IN HIPY OCCUP	YES N	0	YES [NO 🗆	
9	וו כ	OR CONTRIBUTING		110.00	M. MONTH D	DAY YEAR	11011011	N VOKT OCCOR	(ENTERNATURE	OF INJURY IN	IIEM IS PARI	TORPART 2)		
1	DIC.	(IF EITHER NOTIFY MEDIC		P.		19	21f LOCAT	ION						
	ME	WHILE NOT WH			EET, FACTORY, OFFICE,	FARM ETC)	STRE		c	TY OR TOWN		COUNTY	STAT	E
		AT WORK AT WO	RK -	l 1 1 1		() CL		10 7 6	-	0 -	-	05		
		22a. I certify that (I) sow the decease		00110	e deceased from	04	d that in (m		death occurred o	the date	and how as		that (I) (we)	
9	ű:	above, (I) (we) (c	del (did not	view the body	ofter domb		DEGREE	y) (001) Opinion	dedili occorred o	- The date	0110 11001 01			0
		III. SIGNATORE	00	3 61	the Kita	0 Xa -	4/11	ATTENDING	MEDICAL _	STAFF		22c. DATE	STONEY C	/
#		27d PHYSICIAN'S NA	AMP LIVE	Pare NO	Ches Al Tobal	E Lilling	22e ADDR	PHYSICIAN (DIRECTOR	PHYSICIAN	V	1/2/	10	7
		RIGHARD			ND ON				RIVE, KCL	MPEDI	AND N	/D 21 F	00	
-	22. 0	URIAL, CREMATION.		,		NAME OF C		CREMATORY	123d LOCATIO		יו, טוואים	ID 215	02	
		SPECIFY)	KEMOVAL	23b. DATE					CITY OR T	OWN	4.5	VINIO	STATI	E
	24 FI	Burial INERAL DIRECTOR		Dec.7,	1907 KE	est L	awn M		dens La			Leg.	, MD	
4	2,10	John J.	Un fo	m Tm	ADDRESS	10 140	0		EU 910	285	REGISTRA		Munda !!	4
		OOIIII J.	пате	I', UI'.	raval	Le, M	U		O K	20				- 6

DHMH - 16 60M 7/8 (VRA 15, 4)

Teachers and I Sadder HEART HOSE ITAL Allegen word and the property of the contract object to the state of the stat we of a grant principle to a 15-15 March Spacker Rebestion- Labort Lab. Color. The second of th RICHARD SCHITT, I HO 900 SETON LATVE, MCNMEDIANT, HE 21502 Threat I are the company of the comp John J. Heiser, Jr. Lavele, po. 13,000

			FOR			DEPARTM			ARYLAN AND MI		HYGIEN	IE S	ن دُ	2 3	1	
250	3059		STATE REGISTRAR		N	NEDICAL E	XAMINE	R'S CE	RTIFIC	CATE	OF DEA		REG. NO.	/		
300			EASED NAM OR PRINT)	E FIRST Lind	a	Caro	1.		lifr	itz		20 DATE KNO OF ES DEATH MA	TI	12 11	19 85	26. HOUR 9:45 M
	SARY, PLEASE AL DIRECTOR. YOUR FILES. IN 72 HOURS	3. SEX	emale	4. RACE White	5. DATE OF BIR MONTH D Aug. 1	AY YEAR	AGE (IN YEAR LAST BIRTHDAY	MONTHS	ER 1 YR.	HOURS	R 24 HRS. MIN.	2c. DATE PRONOUNCED DEAD		12 11	19 85	2d. HOUR
	NECESSARY, FUNERAL DII 5 FOR YOU 7 WITHIN 72	7a. 81	RTHPLACE (S REIGH COUNTRY) Va		76. CITIZEN OF	WHAT COUNT	RY?		NE'	VER MARK		9 BALTIMORE Allegai	_			
	PAGE S THE P	10. CI	ty or town uke		11. NAME OF H	HOSPITAL, NURS H FACILITY, GIVE STR Mullan	SING HOME, EET ADDRESS) Ave	or other	RINSTITU		12a. USI	JAL OCCUPATION OF PUNCI	ON (TYPE O	F WORK 12b.	KIND OF BU OR INDUST Said I	RY
201	ANY D AND 3 RETAIN CUID HEOFE	USUA 13a S		(IF IN NURSING HOME	or other institution inty	13c. CITY C	OR TOWN		3d. INSIDE (I	TY LIMITS?	13e. STR	fiqdoressi	lan A	ve Iul	540 ke Md.)
WD	AGES 1, 2, ORM PM 3. 1 AND 2. 1 OF VIKA	14. FA	Gera.	E	WIDDIE	Gı	st Ly		F	rst Joan	EN NAME	MIDDLE		(Seaber	
BALTIMORE,	B. GIVE PAGE WITH FORM PAGES 1 AND DIVISION OF	16a. V	VAS DECEASE ES, NO. OR UNKNI NO	D EVER IN U.S. A	RMED FORCES? VE WAR OR DATES)	16MSDE	S SECURITY	100	7. INFORA		llif		DDRESS	d.		
ST., BA	24 HOURS ITEM 18. G LONG WIT PERMIT. PA SIENE, DIVI		18 CAUSE C PART I D	EATH WAS CAUS	only one cause per ED 8Y: ATE CAUSE (o)	line for (o), (b),	and (c).)	ous	Cel	PC	acci	umic	201	+	APPROXIMAT BETWEEN ONSE	E INTERVAL T AND DEATH
RESTON	24 TEV			ins, if any, which	b DUE TO,	OR AS A CONS	EQUENCE OF	the	me	tari	tan	iz.				
31 W. P.	\bigcap			ise to immedia) stating the <u>unde</u> use lost.		OR AS A CONS	EQUENCE OF	-				WE'S				
ORDS, 3		z	PART 2 OTHER S	IGNIFICANT CONDITION	NS CONTRIBUTING TO OF	ATH BUT NOT RELATE	O TO THE TERMIN	AL DISEASE (OR CONOITIO	N GIVEN IN P	'ART 1 (a).					
DIVISION OF VITAL RECORDS, 301 W. PRESTON ST.,	SHOULD BOND "PEND CHIEF E USED I OF HE	CERTIFICATION	190. DATE O	F OPERATION	196 COI	NDITION FOR W	HICH OPERA	TION WA	S PERFOR	MED?				2	YES	? NO 🗆
ON OF VI	FICATE THE WC OULD B OULD B TO BUR	AL CERT	UNDERLYIN	AL CAUSE WAS GOR ING CAUSE O	HOUR	OF INJURY A.M. MONTH P.M.	DAY YEAR	21c. HO	W INJURY	OCCURR	ED (ENTER	NATURE OF INJURY I	N ITEM 18 PAR	RT 1 OR PART 2)		
DIVISIO	E E E E E E E E E E E E E E E E E E E	MEDICAL	21d. INJURY WHILE AT WORK	OCCURRED NOT WHILE AT WORK		CE OF INJURY FACTORY, FARM, ETC		21f. LOC STI	ATION REET			CITY OR TOWN		COUNTY		STATE
	F . 3 & F Z			ify that I taak cha	rge of the remains	described abov		Autapsy	Hamie	Inspecti		Inquiry 4		in my opinic	on	
	AL EXAMINER: HE CERTIFICATE HOULD BE FOR AL DIRECTOR: TH, WITH THE S: MARYLAND, 2	1	ACTUAL SIGNATURE	A	rance	isco	leye	M.I	TITLE (S	5-1-1	-	DICAL EXAMINE		DATE SIGNED_	12-11-	85
	DIC NER SI		EXAMINER'S	NAME /	rancis	eo Re	yes	A	DDRESS.	100:	Setor	0	unbe	rlaw	1,14.	21502
	AS EXECUTED AS A PAGE AS A PAGE A PAG	23a. 8	URIAL, CREMA SPECIFY) Buri	al A	236. DATE 13-1	1-15 23c. N.	AME OF CEM	PYOR	CREMATO	ORY S	23d. LG	CATION PRIOWN	Seul	o Louth,	legan	L Metat
	DHMH - 17 (VR A15 ME (5))		Boal F	CTOR I	ervice W	esterno	ort Md	e		DEC.	16 f	Y REGISTRAR, 2	Sb. REGIS	PAR'S SIG	VATURE	-

The land to a Tay handleder yet T The state of the light of the second of the . ectimes.

		VERAL HOME	STATE OF MARYLAND	8 5 5 2 5 1 4
00000	1 - STATE 2 E. MAIN	N ST DEPAR	TMENT OF HEALTH AND MENTAL HYC	GIENE
006205	REGISTRARFROSTBURG	G, MD 21532	CERTIFICATE OF DEATH	REG. NO.
m.c	1. DECEASED NAME FIRST (TYPE OR PRINT)	MIDDLE	LAST	20. DATE OF DEATH MONTH DAY YEAR 26. HOUR
4 may be tor, page 3 after death	MARTE	AGNES	FARRELL	DECEMBER 18, 1985
a d d	3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.
rs of	FEMALE	WHITE	JAN. 2, 1907	78 YRS. MONTHS DAYS HOURS MIN.
Po Po Po	70. BIRTHPLACE (STATE OR FOREIGN	76. CITIZEN OF WHAT COUNTR	Y? 8 MARRIED NEVER MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH
n 72	MARYLAND	U.S.A.	WIDOWED DIVORCED	ALLEGANY COUNTY MD.
10 Mg King G	10. CITY OR TOWN OF DEATH		SING HOME OR OTHER INSTITUTION	126 USUAL OCCUPATION 126 KIND OF BUSINESS OR
10 s of the s	CUMBERLAND	SACRED HEART		TEACHER INDUSTRY
212	USUAL RESIDENCE (IF NURSING HOME O	ROTHER INSTITUTION, GIVE RESIDENCE BEF		13e STREET ADDRESS / ZIP CODE
AND 24 filleo ould bould		EGANY MT. S		13e.STREET 3DDRESS STREET, 21545
rely 2 sh	14 FATHER'S NAME	MIDDLE LAST	15. MOTHER'S MAIDEN NA	
AM B CONTRACTOR	ROBERT	BIRMINGH	am Fränces	TRIMBLEST
Je and Co	160 WAS DECEASED EVER IN U.S. AF	RMED FORCES? 166 SOCIAL SE		ADDRESS
IIW	(YES, NO OR UNKNOWN) (IF YES, GI	217 28	9756 EDWARD J.	FARRELL, SAME AS 13e
SALI	18. CAUSE OF DEATH (Enter a	nly one cause per line for (a), (b), ED BY:	and (c).	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 1 211		TE CAUSE (a) Carolia	e anen posible	Vew MI c Mahfrant on the
NO E DE DE DE		DUE TO, OR AS A CONSEC	DUENCE OF	4
EST OF THE PARTY O	Conditions, if any, which	(16) Sera	& CADO M	error MI
4 1111	gave rise to immediate cause (a), stating the	DUE TO, OR AS A CONSEC	DUPNCE OF A	
on when the season of by season of a by or orthogon or orthogon or	underlying cause last	(c) Hyell	Musury Carde	Warilly allen
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 2120 ING PHYSICIAN: The fow requires that the seathers and 2 should be filled in by os the buriot-transit permit. The modes remained by the additional department of the properties of the buriot-transit permit. The modes remained by the ord Memol Hygician prior to buriot common to a should be filled in by orked or hem 18 she ream, injury, or other transmitter as medical associater having being orked or hem 18 she ream, injury, or other transmitter events as medical associater having being the medical associates.	PART 2. OTHER SIGNAPICANT	CONDITIONS CONTIBUTING T	O DEATH BUT NOT RELATED TO THE TERM	MINAL DISEASE OR CONDITION GIVEN IN PART 110
ORO	9/4/0	It deate	eres controlled	artacles
REC OF THE PARTY O	190 DATE OF OPERATION 210. ACCIDENT WAS UNDERLYING	196 CONDITION FOR WHI	CH OPERATION WAS PERFORMED	200 AUTOPSY? 200 JEYES, WERE FINDINGS USED CERTIFYING CAUSES OF DEATH?
VITAL N: Th nysicie rensit Hygier 18 she	71a. ACCIDENT WAS UNDERLYING	7 21b. TIME OF INJURY	21. HOW INTERPOCCUE	YES NO YES NO
JAN: T physical inficote tronsition of Hygin		LIGHT A LA CALTELL	DAY YEAR	KED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
ON OF HYSICIA Iding ph horiol-th Mental or Item 1	OR CONTRIBUTING CAUSE OF DE (IF EITHER, NOTIFY MEDICAL EXAMINE 21d. INJURY OCCURRED	P.M. 21e. PLACE OF INJURY	21f. LOCATION	
PH tend tend the b		(AT HOME, STREET, FACTORY, OFFIC	E. FARM. ETC.) STREET	CITY OR TOWN COUNTY STATE
DIVISION DIVISIONI DIVISION DIVISION DIVISION DIVISION DIVISION DIVISION DIVISIONI DIVISI	A) WOME	Selven and the decree of the	9/9 93	12/12/25
OR: OR: 1 is 1	sow the deceased alive or	itol) attended the deceased from	3	deoth occurred on the date and haur and from the causes stoted
RECT SECT Sed for on 2	above, (1) (we) (did) (did no 22b. SIGNATURE	at) view the bady after death.	DEGREE	22c. DATE SIGNED /
L OR A L DIRECTOR OF THE HOUSE	11/	10%	ATTENDING	MEDICAL STAFF 17/2/1/
O HOSPITAL (O HOSPITAL (TO FUNERAL I TO FUNERAL I With the State (MADORTANT: II	22d. PHYSICIAN'S NAME (117PE	OR PRINT)	PHYSICIAN [DIRECTOR PHYSICIAN 14/2//85
HOSPI ined b FUNE wild be	TO THE TOP		925 BISHOP	TATICU DD CTMDE'DT AND MD
TO HO Shault with the MAN Author	V.r. FET.TPA 236 BURIAL, CREMATION, REMOVAL	23b. DATE 23	NAME OF CEMETERY OR CREMATORY	WALSH DR. CUMBERLAND, MD
BP	BURTAT.			CITY OR TOWN COUNTY STATE
	24 FUNERAL DIRECTOR	DEC .21 85	ST PATRICK CEM.	MT SAVAGE, MD. EREC'D. BY REGISTRAR'25B. REGISTRAR'S SIGNATURE
DHMH - 16 50M 4/83 (VRA 15, 4)		L HOME, FROSTBU		2 4 4005
(**************************************	DOLOT LONGICA	THOUSE THOUSE	RG, MD. 21532 ULL	3 Land Auto Builder But a

Epochanica, Id. 21632 CELL ALL SHE VOLT . ARRESTOR THE than, mann of a to the Marketing , SK Market and Trans. SEE AS SEE A COUNTY OF THE SEE SEE SEE SEE ASSESSMENT OF PERIOD OF THE PROPERTY OF THE PR ALS DISCOPTABLE IV. COMMINGAND, 4D PERSONAL REPORT OF THE PROPERTY OF THE PROPERT

mpletely filled in by the funeral director page 3 and 2 shauld be filed within 72 hours after death DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201 TO FUNERAL DIRECTOR:

STATE OF MARYLAND FOR STATE

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

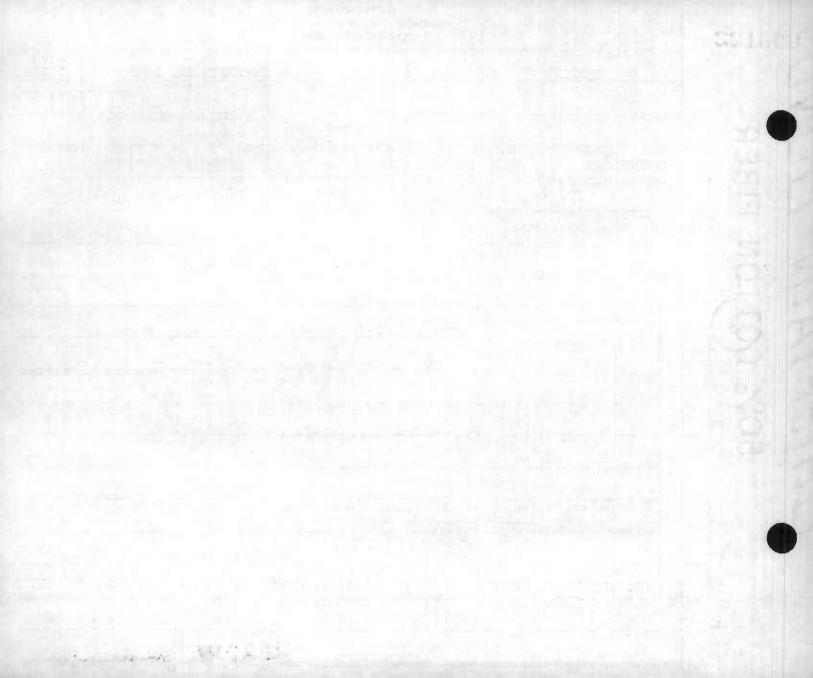
	REGISTRAR					REG. 1	10.						
	DECEASED NAME FIRST TYPE OR PRINT)	WIDDLE	l.	AST	20	DATE OF DEATH	MONTH	DAY YEAR	9:16				
	RUSSELL	ALVIN	FLAKE		Di	ECEMBER 2	2, 198	35	9. ¥0 w				
3.	SEX	4 RACE	5. DATE C			AGE (IN YEARS LAST B	RTHDAY	MONTHS DAYS	IF UNDER 24 HRS				
-	male	white	Ol	30-1905 TEA		80	YRS	DAYS	MIN.				
70	BIRTHPLACE (STATE OR FOREIGN	76. CITIZEN OF WHAT COUN	TRY? 8	NEVER MARRIED	9.1	BALTIMORE CITY	OR COUNT	Y OF DEATH					
1	MD	USa	WIDOWE			ALLEGA	NY		MD.				
10	CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NU (IF NOT IN SUCH FACILITY, GIVE S		R OTHER INSTITUTION		USUAL OCCUPATIVE OF WORK FOR MOST		126 KIND O	F BUSINESS OR				
	CUMBERLAND	MEMORIAL H				retired		Brewi	ng Co.				
	SUAL RESIDENCE (IF NURSING HOME OF			13d INSIDECITY LIMI	ITS? 130	STREET_ADDRESS	/ ZIP COD	6					
1	MD A11	egany 13c Cumbe	erland	YES NO		STREET ADDRESS	ederic	k Stree	t/21502				
14	FATHER'S NAME	AND DIE LAST	NO.	15. MOTHER'S MAIDE		MIDDLE		ŁAS'					
	William	Flake		La	vaini	ia Brownii	ng						
16	WAS DECEASED EVER IN U.S. AR		SECURITY NO.	17 INFORMANT	7	ADDI			1.0				
	(YES, NO OR UNKNOWN) (IF YES GIV	218-1	6-2762	Mrs. Haze	1 P.	Flake, C	umberl	and, MD	- wife				
Г	18 CAUSE OF DEATH (Enter or	nly ane cause per line far (a), (b	, and re			1		APPROXI BETWEEN	MATE INTERVAL				
	PART I. DEATH WAS CAUSE	TE CAUSE (a)	ndu	is a	RIC	est							
		DUE TO, OR AS A CONSEQUENCE OF											
	Canditions, if any, which												
	gove rise to immediate cause (a), stating the DUE TO, OR AS A CONSEQUENCE OF												
	underlying couse last.	(10)	ande	ochemi		Alpe	12						
	PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 in												
CEDTIEICATION													
7 3	190 DATE OF OPERATION	196 CONDITION FOR WE	HICH OPERATIO	WAS PERFORMED		200 AUTOPSY? 206. IF YES, WERE FINDINGS US IN CERTIFYING CAUSES OF DE							
100		2 K 1 1 1 2				YES NO		ES [NO [
1 8	210 ACCIDENT WAS UNDERLYING	THOUSE A ALL MONITHS	DAY YEAR	21c. HOW INJURY O	CCURRED	(ENTER NATURE OF INJ	URY IN ITEM 18	PART I OR PART 2)					
14	OR CONTRIBUTING CAUSE OF DEA		19										
MEDICAL	21d INJURY OCCURRED	21e PLACE OF INJURY		211 LOCATION	CITY OR I	OWN	COUNTY	STATE					
1 3	WHILE NOT WHILE AT WORK	HILE											
	22a I certify that (I) (this hospi	220 certify that (1) (this haspital) ottended the deceased from 12/22 19 55, to 12/22 19 82, that (1) (we) last											
	saw the deceased alive on	saw the deceased alive an 2 19 . and that in (my) Jour) apinion death accurred an the date and have and from the causes stated above, (I) (we) (did) (and nat) frew the body after death.											
	22b. SIGNATURE	22c. DATE	SIGNED										
	IN	Ilcles	ING TAB	MEDICAL STA	AFF	12/	24185						
	224 PHYSICIAN'S NAME (TYPE C	OR PRINT)		PHYSICIAN DIRECTOR PHYSICIAN D									
	DR. WILLIAM P	. IAMES		441 N. CE	CUMBE	RLAND, M	D 21502						
23	BURIAL, CREMATION, REMOVAL		23¢ NAME OF C	EMETERY OR CREMAT	ORY	23d LOCATION							
	(SPECIFY) Burial	12-24-1985	Pleasan	t Grove Ce	em.	Cumber	land	ATTegan	y MD ^{TE}				
24	FUNERAL DIRECTOR				o. DATE RE	C'D. BY REGISTRAL	25b. REGIS	TRAR'S SIGNATI	JRE				
	James F. Scarpe	elli, Cumberî¤ñ	nd, MD 2	1502	UEC	37.1995	Julie	Davidson	Bandaga.				

DHMH - 16 60M 7/84 (VRA 15, 4)

BP.

should be detached far use as with the State Dept. of Health

MPORTANT: If Hem 21 is



director, page 3

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201 TENDING PHYSICIAN: The law

1 - STATE REGISTRAR

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REGISTRAN		REG. NO.									
1 DECEASED NAME FIRST MIDDLE	LAST	20. DATE OF DEATH MOT	NTH DAY YEAR	2b. HOUR							
CHARLES CLIFTON	FLETCHER	December 5,	1985	2:45.							
3. SEX 4. RACE	5 DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDA	IF UNDER 1 YEAR	IF UNDER 24 HRS							
MALE WHITE	OCTOBER 12 1904	81	YRS. MONTHS DAYS	HOURS MIN.							
76. BIRTHPLACE (STATE OR FOREIGN 76 CITIZEN OF WHAT COUNTRY?	MARRIED X NEVER MARRIED	9 BALTIMORE CITY OR C	OUNTY OF DEATH								
MARYLAND USA	WIDOWED DIVORCED	Allegany		MD.							
10 CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING (IF NOT IN SUCH FACILITY, GIVE STREET A		126 USUAL OCCUPATION		OF BUSINESS OR							
Cumberland Memorial Ho	ospital	RETIRED CELA	ANESE CORP.	SŢLK							
USUAL RESIDENCE (IF MURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE	1 13d INSIDE CITY LIMITS?	1818 FREDER	CK STREET	1502							
14 FATHER'S NAME	IS MOTHER'S MAIDEN NA	ME	(A								
COURTNEY A. FLETCHER	GRACE	MIDDLE	ADAMS								
166 WAS DECEASED EVER IN U.S. ARMED FORCES? 166 SOCIAL SECUR	RITY NO. 17. INFORMANT	ADDRESS									
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) 217-10-15	515 ETHEL FLETCHE	R 1818 FREDER	RICK ST CUN	BERLAND 1							
18 CAUSE OF DEATH (Enter only one couse per line for 10), (b), and			BETWEEN	DASE HUSEVAL ONSET AND DEATH							
IMMEDIATE CAUSE (o)	PART I, DEATH WAS CAUSED BY										
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if ony, which (1b)											
gave rise to immediate couse (a), stating the DUETO, OR AS A CONSEQUENCE OF											
underlying couse last											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING/TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART TIO											
O (V & multiper vecu	met										
196 DATE OF OPERATION 196 CONDITION FOR WHICH C	OPERATION WAS PERFORMED	200 AUTOPSY? 206 IF YES, WERE FINDINGS US IN CERTIFYING CAUSES OF DE									
190 DATE OF OPERATION 196 CONDITION FOR WHICH O		YES NOV	YES	NO []							
OR CONTRIBUTATE DE CAUSE OS OF THE HOUR A.M. MONTH DA	Y YEAR 216 HOW INJURY OCCURE	RED (ENTER NATURE OF INJURY IN	ITEM 18 PART OR PART 2)								
(IF EITHER, NOTIFY MEDICAL EXAMINER) P.M.	19										
ш	Id INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME STREEL, FACTORY, OFFICE FARM, ETC.) 211 LOCATION STREET CITY OR TOWN										
WHILE NOT WHILE AT WORK AT WORK											
220 1 certify that (1) this hospital) attended the deceased from											
the body difference in body differ deding	sow the deceased alive and 12 - 4 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1)/(we) (did) fall not view the body after death.										
22b. SIGNATURE											
aystum m. D. ATTENDING MEDICAL STAFF 12-5-8											
	22d PHYSICIAN'S NAME (1YPP/OR PRINT) 22e ADDRESS 955 Frederick Street										
Dr. Anthony Bollino	Cumbe		1502								
(SPEC(FY)	AME OF CEMETERY OR CREMATORY	23d LOCATION	COUNTY	STATE							
BURIAL DEC 8 1985 SUNS	SET MEMORIAL PARK		ALLEGANY M	ARYLAND							
24 FUNERAL DIRECTOR NAME ADDRESS	250 DATI	REC'D. BY REGISTRAR 25b	REGISTRAR'S SIGNAT	URE							
CTT COTT 1 COM	JMBERLAND MARY AND	3 1900 gu	an Harrison	with .							

DHMH - 16 60M 7/84 (VRA 15, 4)

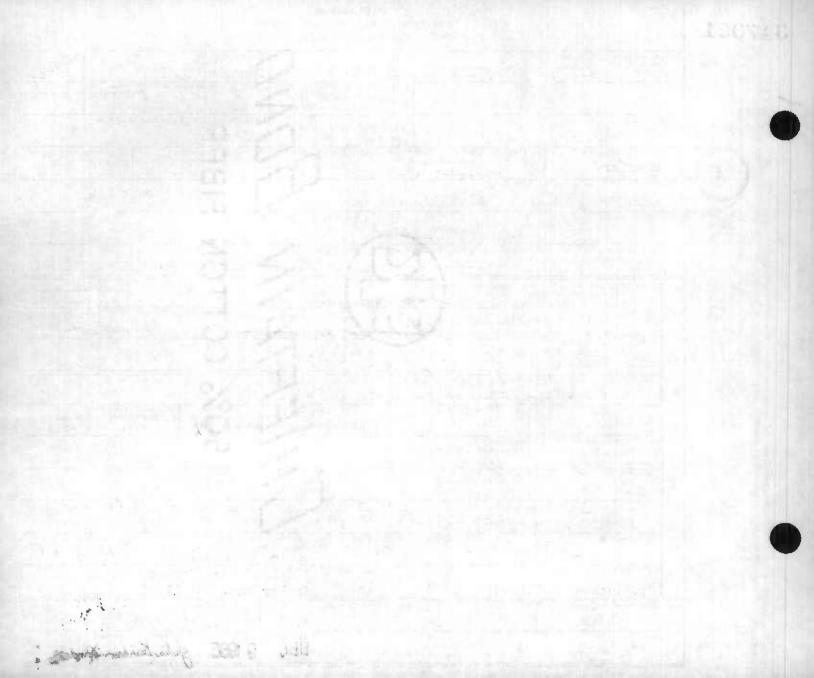
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physicion and cample should be detached for use as the burial-transit permit. Then please remave carbanpapers. Pages. I are with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remaval.

etoined by the hospital or attending physician

BP.

injury, or other traumotic event, the medical

MPORTANT: If Item 21 is morked or Item 18 shows any



00

DHMH - 16 60M 7/B4 (VRA 15, 4)

365171

FOR

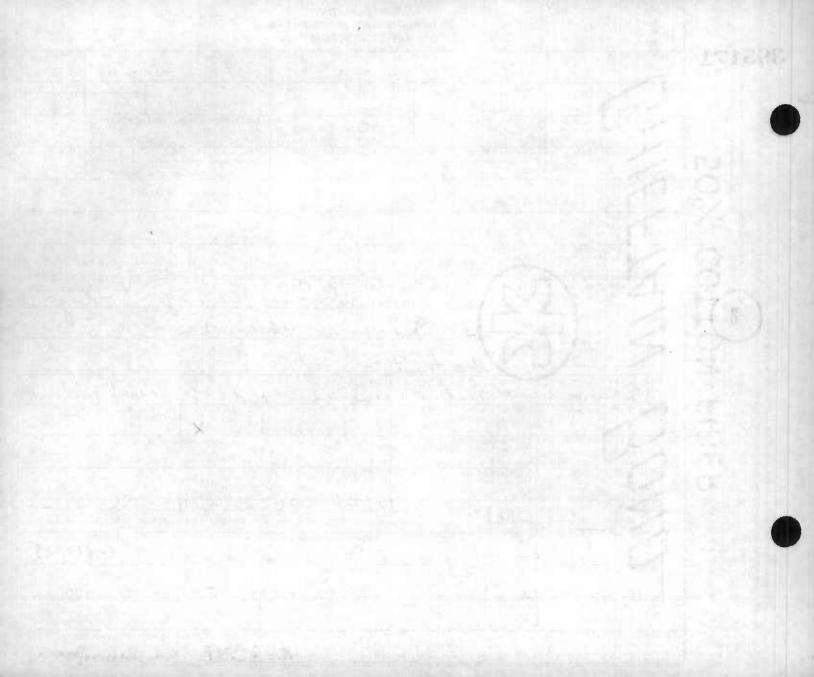
- STATE

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REGISTRAR REG. NO DECEASED NAME MIDDLE LAST 20 DATE OF DEATH ALCONITIE DAY 7b HOUR FIRST TYPE OF DOOR T Agnes Frankland 85 MARTE 5 DATE OF BIRTH 6 AGE (IN YEARS LAST BIRTHDAY) 4 RACE 3 SEX MONTH DAY YEAR Female White TO BIRTHPLACE ISTATE OF FOREIGN 76 CITIZEN OF WHAT COUNTRY? BALTIMORE CITY OR COUNTY OF DEATH MARRIED NEVER MARRIED WIDOWED DIVORCED MARYI AND Allegany County NAME OF HOSPITAL NURSING HOME OF OTHER INSTITUTION 10 CITY OR TOWN OF DEATH 120. USUAL OCCUPATION 126 KIND OF BUSINESS OR (TYPE OF WORK FOR MOST OF WORKING LIFE) INDUSTRY (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOUSE WIF Frostburg Frostburg Community Hospital 130. SIATE MARYLAND 811 SHRIVER AVE 13d INSIDE CITY LIMITS? YES IX NOF 14 FATHER'S NAME 15. MOTHER'S MAIDEN NAME MIDDLE JOHN H. BOETTNER MARY WHITEFIELD A. ADDRESS 17 INFORMANT 160 WAS DECEASED EVER IN U.S. ARMED FORCES? 166 SOCIAL SECURITY NO. LIE YES GIVE WAR OR DATEST ANNA CURL 3200NORTH EAST 18 CAUSE OF DEATH (Enter only one couse per line) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o). Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION ON PART 1:0 CERTIFICATION 20b. IF YES, WERE FINDINGS USED 196 CONDITION FOR WHICH OPERATION WAS PERFORMED 20g AUTOPS IN CERTIFYING CAUSES OF DEATH? YES NO F 710 ACCIDENT WAS UNDERLYING 216. TIME OF INJURY 211. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) HOUR A.M. MONTH DAY YEAR OR CONTRIBUTING T CAUSE OF DEATH WEDICAL LIF EITHER NOTIFY MEDICAL EXAMINER P.M. 71d INJURY OCCURRED 71e PLACE OF INJURY 211 LOCATION CITY OR TOWN COUNTY STATE (AT HOME STREET, FACTORY, OFFICE, FARM ETC.) WHILE NOT WHILE 220.1 certify that (1) (this haspital) attended the deceased from sow the deceased alive on__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not view the body ofter death 226. SIGNATURE DEGREE 22c. DATE SIGNED ATTENDING MEDICAL PHYSICIAN DIRECTOR PHYSICIAN 22e ADDRESS 224 PHYSICIAN'S NAME (TYPE OR PRINT) Lal Sandhir, M.D. 230. BURIAL, CREMATION, REMOVAL 23b. DATE 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION STATE (SPECIFY) BURIAL BURTAL PARK CUMBERT AND ALLEGANY MARYLAND 24 FUNERAL DIRECTOR 750. DATE REC'D. BY REGISTRAR 756. REGISTRAR'S SIGNATURE SILCOX-MERRITT FINERAL SERVICE CUMBERLAND MARYLAND



136 COUNTY

Garrett

MIDDLE

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (0).

ROSE

1. DECEASED NAME

Female

CITY OR TOWN OF DEATH

Levi

Conditions, if ony, which gave rise to immediate cause (a), stating the

710 ACCIDENT WAS UNDERLYING

21d. INJURY OCCURRED

22b. SIGNATURE

OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

NOT WHILE

underlying couse

(TYPE OR PRINT)

COLINITOVI

amberland

Maryland

4. FATHER'S NAME

No

CERTIFICATION

00

3. SEX

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

DAY

7/8/1911

GARLITZ

5. DATE OF BIRTH

WIDOWED

11. NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION

	REG. N	10.
٦	20. DATE OF DEATH	HINOM
1	DECEMBED	00

2h HOUR

	DECEMBER 29, 1	985		8:1	OP M			
	AGE (IN YEARS LAST BIRTHDAY)	IF UNDE	RIVEAR	IF UNDER 24 HRS				
		MONTHS	DATS	HOURS	MIN			
	74 YRS							
,	DALTHAODE CITY OR COUNT	VOLDE	ATLI					

BALTIMORE CITY OR COUNTY OF DEATH MARRIED NEVER MARRIED ALLEGANY COUNTY 170 USUAL OCCUPATION

17h KIND OF BUSINESS OR LTYPE OF WORK FOR MOST OF WORKING LIFE! INDUSTRY

YEAR

1005

Cook Restaurant

13e STREET ADDRESS / ZIP CODE Star Route Box 150

NO V Grantsville 15. MOTHER'S MAIDEN NAME

13d INSIDE CITY LIMITS?

Minnie

Mae Klink Star Route, Box 150

Grantsville, MD Helen Edgar

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

DUE TO OR AS A CONSEQUENCE OF

ANNA

White

TH CITIZEN OF WHAT COUNTRY

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

SACRED HEART HOSPITAL

Garlitz

220-28-9885

13c. CITY OR TOWN

4 RACE

DUE TO, OR AS A CONSEQUENCE OF

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110

HOUR A.M. MONTH DAY YEAR

(AT HOME STREET, FACTORY, OFFICE FARM ETC.)

19h CONDITION FOR WHICH OPERATION WAS PERFORMED

21h TIME OF INJURY

P.M

21e PLACE OF INJURY

YES T 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

200 AUTOPSY?

211 LOCATION STREET CITY OR TOWN

and that in (my) (our) opinion death accurred on the date and hour and from the causes stated 22c DATE SIGNED

MEDICAL ATTENDING MEDICAL STAFF
PHYSICIAN PHYSICIAN F 22e ADDRESS

22d. PHYSICIAN'S NAME (TYPE OF PRINT) SUSAN SCHWARTZ

23a. BURIAL, CREMATION, REMOVAL

Burial

FROSTBURG PLAZA, RTS. 36 & 40 FROSTBURG. MD 23c. NAME OF CEMETERY OR CREMATORY

Avilton,

Garrett,

MD

DHMH - 16 60M 7/84 (VRA 15, 4)

(SPECIFY)

23b. DATE

220.1 certify that (1) (this hospital) attended the deceased from sow the deceased alive on abo (did not) view the body after death

Grantsville, MD

AND DATE RECD. BY BEGISTERE 256 BEGISTERE'S SIGNATURE

าใส่สารากับเราายาวราธ

DECEMBER 29, 1985 Bilder

YDIND YIMBUL

AGEED HISAT HISELIAL

			RAL HOME		STATI	E OF MARYLAND	0 0	5 2	011	
3003	1 -	FOR BOX 37 STATE REGISTRAR CONFLUENCE	CF PA. 1	DEPARTM 5424		EALTH AND MENTAL HYG	IENE			
0000	I DEC	CEASED NAME FIRST		MIODLE		AST	REG. NO	D. MONTH DAY	YEAR IZE HOUSE	
± 3		OR PRINT)							20 119:	
page 3	3. SEX	WILMA	14 RACE	ATHERMAN	5. DATE C	EORGE	DECEMBER 28	/	NOER I YEAR IF UNDER 2	
offe.						DAY YEAR		MONT	HS DAYS HOURS	
direct ours		RTHPLACE (STATE OR FOREIGN	White	WHAT COUNTRY?	NO	v. 23 1915	70	YRS.	DEATH	
unerol o	(Va.	U.S.	A.	MARRIED NEVER MARRIED WIDOWED DIVORCED					
by the filled with	1	Cumberland	SACRE	ED HEART H	OSPIT	PROTHER INSTITUTION	120 USUAL OCCUPATION (TYPE OF WORK FOR MOST OF Housewife	F WORKING LIFE)	126. KIND OF BUSINESS INDUSTRY Own Home	
filled in rould by	13a. S	AL RESIDENCE (IF NURSING HOME OF TATE 13/ COU		GIVE RESIDENCE BEFORE 13c. CITY OR TOWN Addis	V	13d INSIDE CITY LIMITS?	13e.STREET ADDRESS /		5411 9999	
mpletely ond 2 st	14 FA	THER'S NAME Frederick	WIDDLE	Linkous		15. MOTHER'S MAIDEN NA. Margaret	ME MIDDLE		Moore	
d co		VAS DECEASED EVER IN U.S. AI		166 SOCIAL SECU	RITY NO.	17 INFORMANT	ADDRE	55		
Pog ned	(,	No	IVE WAR OR DATES)	226-14-2	672	Patricia Me	yers Addis	on Pa.	15411	
ysicio ppers		18 CAUSE OF DEATH (Enter of PART I. DEATH WAS CAUSI IMMEDIA	nly one couse per ED BY:	r line for Fune	Ca	uce Metast	ate to B	Laur	APPROXIMATE INTERV. BETWEEN ONSET AND DI	
by the attended of contraction		Conditions, if ony, which gave rise to immediate cause (a), stating the underlying cause lost.	(b)_	PR AS A CONSEQUE						
equires in signed. Then ple r to burio injury, ar	NOI	PART 2 OTHER SIGNIFICANT	CONDITIONS C	ontributing to D	EATH BUT	NOT RELATED TO THE TERM	IN AL DISEASE OR CONI	DITION GIVEN I	N PART 10	
he idw in hos bee it permit.	CERTIFICATION	190 DATE OF OPERATION	19b. COND	ITION FOR WHICH	OPERATIO	N WAS PERFORMED	200 AUTOPSY? YES NO	20b. IF YES, WE IN CERTIFYING	ERE FINDINGS USED G CAUSES OF DEATH NO	
- 10 5 to 45	4 100 1	210. ACCIDENT WAS UNDERLYING	216. TIME C	OF INJURY		101 11011111111111111111111111111111111		V 45. 17544 10 0 4 07 1		
Z & S D T &		OR CONTRIBUTING CAUSE OF DE	2111	.M. MONTH DA	Y YEAR	21c. HOW INJURY OCCUR	RED (ENTER NATURE OF INJUR	THE TO PART I	OR PART 2)	
S	MEDICAL CE	OR CONTRIBUTING CAUSE OF DE	R) P	M. MONTH DA	19	211 LOCATION STREET	CITY OR TO		COUNTY STA	
certification of participation of partic		OR CONTRIBUTING CAUSE OF DE (IF EITHER NOTIFY MEDICAL EXAMINE 21d IN JURY OCCURRED WHILE NOT WHILE	P P 21e PLACE (AT HOME ST	.M. MONTH DA .M. OF INJURY REET FACTORY OFFICE FA	19 ARM ETC)		CITY OR TO	WN 19_	COUNTY STA	
the hospito or attending plant hospito or attending plant. A DIRECTOR: After this certification of the puriolities of the puriolities of Health and Mental it. If hem 21 is marked or hem.		OR CONTRIBUTING CAUSE OF DO (IF ETHER NOTIFY MEDICAL EXAMINE 21d IN JURY OCCURRED WHILE NOT WHILE 220.1 certify that saw of the control of th	21e PLACE (AT HOME ST	.M. MONTH DA .M. OF INJURY REET FACTORY OFFICE FA	19 ARM ETC) or	211 LOCATION SIREE 19 19 10 that in (my) (aur) apinion DEGREE ATTENDING PHYSICIAN	CITY OR TO	te and have and	COUNTY STA	
by the hospital or attending in the hospital or attending in the Hospital or attending in the detached for use os the busiolities of the order of Health and Mental and Health and Mental is marked or them.		OR CONTRIBUTING CAUSE OF OR (IF EITHER NOTHY MEDICAL EXAMINE 21d IN JURY OCCURRED WHILE NOT WHILE AT WORK NOT WHILE SOW DOWN THE NOTH HIS NOTH	21e PLACE (AT HOME ST	.M. MONTH DA .M. OF INJURY REET FACTORY OFFICE FA	19 ARM ETC) or	211 LOCATION SIREE 19 19 10 10 10 10 10 10 10 10	city or to	ote and hour and	that (I) (we define the causes state 22c, DATE SIGNED	
aby the Assistance of the Assi	WEDICAL 230. B	OR CONTRIBUTING CAUSE OF DE LIFE ETHER NOTIFY MEDICAL EXAMINE 21d INJURY OCCURRED WHILE NOT WHILE SOWN COMMON CO	21e PLACE (AT HOME ST	M. MONTH DA M. OF INJURY REET FACTORY OFFICE FA	19 ARM EIC)	211 LOCATION STREET 19 Indication (my) (our) opinion of the physician 22e ADDRESS	city or to	ote and hour and	that (I) (we define the causes state 22c, DATE SIGNED	

ACCOUNTS ON THE PARTICIPATION OF THE PARTICIPATION

MILYA LEATHERMAN GEORGE DICEMBER 25, 1985 erle ...t. 3115 70 YDESO, WATELIA Jumperland SickED FEART HISPITAL Loureville Sam Lone 15.11 rederick d Lincous entert word .o stricia cons dison . 1,111

RICHORD SCHIFF, NO. 900 SETON DRIVE, QLEVERIN DATE 21502

usial use. 11, 85 Milison was how with the son we are at

000444		OR				DEPART	STAT MENT OF I		ARYLAN AND M		IYGIENI	E O	ن	2	Ġ	1 4	3		
008141		TATE EGISTRAR			MED	DICAL	EXAMIN	ER'S C	ERTIFIC	CATEC	F DEA	TH	REG. NO	o.					
A 8. 8. 8. F.		ASED NAME		iam Ir	rvin G	MIDDLE Sephai	rt		LAST			OF DEATH	ESTI-	12	30	YEAR 19 85	26 HOUR		
HEASE DIFFTOR TZ HOURS ON STREET	3. SEX		Cau	S. DATE	1 04	YEAR	6. AGE (IN YEA	Y) MONT		IF UNDER		RONOUNC DEAD	CED	12	30	YEAR 1985	1630		
REFERENCE WITHIN 72		HPLACE (ST	ATE OR	76 CITIZ	USA	AT COUN	ITRY?	8. MARRI WIDOW		VER MARR	IED [9. BALTIMO	e ga ny	_	TY OF D	EATH	MD		
ER DEATH IF ANY DELAY IS PAGES 1, 2, AND 3 TO THE FLORM PM 3. RETAIN PAGE 5 I AND 2 SHOULD BE FILED, WITH PAGE 5 I AND 2 SHOULD BE FILED, WITH PAGE 5 I AND 2 SHOULD BE FILED, WITH PAGE 5 I AND 5 SHOULD BE 5 I AND 5 I A	Lo	or town on a conii	ng	36	Chur	ch S	RSING HOME TREET ADDRESS) treet		ER INSTITU	NOITI	Ret	AL OCCUPA OST OF SU	ATION (TYPE	E OF WORK	Textille				
AND 3 RETAIN PROUD SHOULD SHOULD	Mary	land	18 IN NURSING HOA	we or other in UNTY egany	STITUTION, GIV	13c CITY	BEFORE ADMISSION OR TOWN		13d. INSIDE C	ITY LIMITS?		et addres Churc		eet	21	639			
DRE, MD DEATH, I GES 1, 2, M PM 2 3 AND 2 3 OGVITAL	I	HER'S NAME Harry		WIDDLE		-	Mart		M	er's maide lary	EN NAME	MID		36	ick		n St		
BALTIMORE RRS AFTER DEA B. GIVE PAGES WITH FORM P C. PAGES I A DIVISION OF A	(YES	им8 пикио		WAR OR DA	TES)		-07-2	731	Mrs.	Eli	zabe	th G	epha:	rtEc	nac	oni	iā:		
: 5,6,3,1,0		PART I DE	F DEATH (Enter ATH WAS CAU IMMED	SED BY:	(a) Car	dio-), and (c).) Dulmona USEQUENCE (rrest							PROXIMATE II VEEN ONSET / Idden	NTERVAL AND DEATH		
L RECORDS, 201 W. PRESTON ST ULD BE EXECUTED WITHIN 24 HOW "PENDING" IN PENCIL IN ITEM 11 FA MEDICAL EXAMINER ALONG FED AS A BURIAL -TRANSIT PERMIT HEALTH AND MENTAL HYGIENE, AL, CREMATION, OR REMOVAL.	V	Conditions, if any, which gave rise to immediate cause (a) stating the under: DUE TO, OR AS A CONSEQUENCE OF									months								
RECORDS, 2011 D. BE EXECUTED PENDING: IN P. AEDICAL EXA AEDICAL FEATTH AND ME. CREMATION, C.	3	lying caus	se lost. NIFICANT CONDITIO	ONS CONTRIBUTI			ry arte								ye	ears			
L RECORDS ULD BE EXE "PENDING "PENDING FF MEDICA HEALTH AI NL, CREMA"			ic lymph																
SHOULD ORD "PEL OR E USED A URIAL, C	CERTIFICATION	19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20 AUTOPSY?								
S S S S S S S S S S S S S S S S S S S	Ē	12/21/	85				opsy,	1ymp	homa						Y	ES 🗆	NO X		
DIVISION OF VITAL RECORDS, S CERTIFICATE SHOULD BE EXECUTION THE WORD "PENDING" ROED TO THE CHIEF MEDICAL BE 3 SHOULD BE USED AS A BUIL E DEPARTMENT OF HEALTH AN OI PRIOR TO BURIAL, CREMATI	3	UNDERLYING CONTRIBUTION	IG CAUSE C	OF DEATH	P.M.	MONTH	DAY YEAR			OCCURRE	D (ENTER N	ATURE OF INJUR	RY IN ITEM 18 F	PART I OR PA	ART 2}				
DIVIS THIS CER WRITIN VARDED PAGE 3 SI TATE DEP	MED	WHILE AT WORK	NOT WHILE AT WORK	²	STREET, FACTO				TREET			CITY OR TOWN	٧	co	YTHU		STATE		
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD. "PEPAGE 4 SHOULD BE FORWARDED TO THE CHIEF A TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED. BATTER DEATH, WITH THE STATE DEPARTMENT OF HE BATTER DEATH, WITH THE STATE DEPARTMENT OF HE BATTER OF THE WARYLAND, 21201 PRIOR TO BURIAL, OF HE		death resulte	y that I taak cho	arge of the r	m//	Accident	17	Autap	, Hamid	Inspection		Inquiry X		d in my a	pinion				
MEDICAL E CUTE THE CUNERAL E FR DEATH,		ACTUAL SIGNATURE_ EXAMINER'S I TYPE OR PRIN	NAME	u		1	~	M	- ph			CAL EXAMI		DATE			31/85		
07/84 BP	_		ION REMOVAL	L 23 DATE	Snow -86	Fro	lame of CEA Stbur	e TERY O	CREMAY EM. F	Memor Pärk		Ospit Tobur					2150 TE		
25M DHMH - 17 (VR A15 ME (5))	24 FU!	E1-CHK	Some	neral	Hom	e, Lo	nacon	ing	Md.	JAN		REGISTRAR	25b REGIS	STRAR'S	- Mari	JRE Leave			

her fluor Ben Cextile

io to some 1215-07-2730 rs. is beth appart

to groups the medianor are the most port of the Library to

Tennors Funeral Zome, Longonting, 4d. [18]

	364136	1	FOR	INIA A	AVE.	21502		RTIF	EALTH AND MENTAL HYG ICATE OF DEATH	REG.		Dr.			
+	be 3		ECEASED NAME PE OR PRINT)	PIRST	VER	NON	(DON	DECEMBER		985	26 HOUR 2:30 PM		
	ge 4 may	3. SI	male		RACE Whi	te			2-08-1920 EAR	6 AGE (IN YEARS LAST 8	VRS	IF UNDER 1 YEAR	IF UNDER 24 HRS		
	Moneral direction	70.8	SIRTHPLACE (STATE OR FOREIGN		76 CITIZEN OF WHAT COUNTRY		M	ARRIEI	DI NEVER MARRIED X	9 BALTIMORE CITY ALLEGAN	OR COUN	TY OF DEATH	MD		
01	s offer d	10 0	Cumberlan		11. NAME OF HOSPITAL, NURSING HO (IF NOT IN SUCH FACILITY, GIVE STREET ADDRES SACRED HEART HOSP I			OME C	OR OTHER INSTITUTION	126. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INDUSTRY NONE					
AND 212	filled in	13a.	JAL RESIDENCE (IF NURS STATE MD	13b. COUN All	other institution TY egany	GIVE RESIDENCE 13c CITY OF CUMD	EBEFORE ADMIS R TOWN PETLANC	d	13d INSIDE CITY LIMITS?	13e STREET ADDRESS	utt S	treet o	2150		
MARYL	mpletely ond 2 st	14 F	ATHER'S NAME FIRST WA	lter î	Gordon	15 A			IS MOTHER'S MAIDEN NA	h Clark MIDDLE		LAS	т		
IMORE,	execut and co	160	WAS DECEASED EVER (YES, NO OR UNKNOWN)		MED FORCES? WAR OR DATES)	166 SOCIAL	SECURITY I	NO.	Mr. William		ress ordon	, Cumber	land, MD		
T., BAL	Ballowell by the		18 CAUSE OF DEATH PART I. DEATH W		y ane cause per BY: E CAUSE (a)	line far tage	De C	(6)	Shock &	Perus	mm	APPROXI BETWEEN (IMATE INTERVAL ONSET AND DEATH		
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 2120	signed by the otherities and place of the otherities of the otherities of the other troumorities or other troumorities.	No	Conditions, if any, gave rise to imm cause (a), statin underlying cause	nediate g the lost	(c)_	R AS A POPU	Rest	e	e Cereb	ebul infaction TERMINAL DISEASE OR CONDITION GIVEN IN PART I IO					
I RECOR	he low rec	CERTIFICATION	19a DATE OF OPERAT	ION	196. COND	ITION FOR W	HICH OPER	ATIO	N WAS PERFORMED	200 AUTOPSY?	IN CER	YES, WERE FINDIN TIFYING CAUSES YES	GS USED OF DEATH?		
OF VITA	ICIAN. Ti g physici g physici errificote iol-tronsit ntol Hygi		210. ACCIDENT WAS UNE OR CONTRIBUTING	AUSE OF DEAT		OF INJURY M. MONTH	H DAY Y	EAR	21c. HOW INJURY OCCURE	RED (ENTER NATURE OF IN.	URY IN ITEM 1	8 PART I OR PART 2)			
IVISION	ottendin ter this c is the bur h and Me	MEDICAL	21d. INJURY OCCURR	RE 🗍	21e. PLACE	OF INJURY REET, FACTORY O	OFFICE, FARM, ET	ici	21f. LOCATION STREET	CITY OR 1	OWN	COUNTY	STATE		
	Spirol or Spirol or CTOR Af for use of of Health		22a. I certify that (1) saw the decease above, (1) (we) (c			1 2	rom 65	an	d that in (my) (aur) apinian	, ta death occurred an the	date and h	our and fram the	that (I) (we) last causes stated		
	TAL OR A the hory the horder DiREcted detached hote Dept.		Chang	DEGREE ATTENDING						MEDICAL ST.	AFF ICIAN []	221. DATE	12/P3		
	O HOSPIT, etoined by TO FUNER should be d with the Sto		CHANG OH	Me frog ca	Property.				48 TA		21532				
	BP		BURIAL, CREMATION, (SPECIFY) Burial	REMOVAL	23b. DATE 12-13	-1985			emetery or crematory emorial Cem.	23d. LOCATION CITY OF TOWN Cumber	land	Allegan	y MD		
	DHMH - 16 60M 7/B4 (VRA 15, 4)	24 1	James F. S	carpe	lli, Cu	mberla	nd, ME	2	1502 ÚE.C	RECD. BY REGISTRA	1256 REGI	STRAR'S SIGNAT	RECO.		

STATE OF MARYLAND

SCARPELLI FUNERAL HOME

SSIME

JACTERON TOWER GEROOF

condition obcase 11 1985

and the second second second

con , c lest a sent a same of the view of the later of the color of YT DOD THE BUILD rates are the edge-to- e-mail x in the venters territory and the training anthron by The course of the state of the second of the MILLANDAR DESCRIPTION OF THE PROPERTY OF THE P Drawing 12/20/0 - order at remarkery contay - minastice in 75.0

and the second of the second

364004	1.	ZFO FOR STATE REGISTRAR			DEF	PARTM	ENT OF H	OF MARYLAN EALTH AND ME CATE OF DE	NTAL HYG	iene	REG. 1	4 0.	2 3	La La
eath see		ORPRINT) CARLI	ETON	1	MIDDLE	НА	NKS,	JR			OF DEATH EC	MONTH 14	1985	1220HRS
ge 4 mo)	3. SE	MALE		4. RACE WH 1	TE		5. DATE C		1921		N YEARS LAST B	RTHDAY)	MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
Cooth. Po		RTHPLACE (STATE OR FOREIGN	GN 7	UNITE	WHAT COUNTY		MARRIEI WIDOWE	NEVER MA	RRIED -	9 BALTIA	ALLE	OR COUNT	Y OF DEATH	MD.
Softer d		JMBERLAND MD					HOME C	OTHER INSTIT		LITYPE OF W	AL OCCUPA ORK FOR MOST pharr	OF WORKING	INDUSTRY	F BUSINESS OR
AND 212 filled in	13a.	AL RESIDENCE (IF NURSING HATE 136 ARYLAND	COUN'	GANY	GIVE RESIDENCE			134 INSIDE CITY	LIMITS?		ARDRESS			21503
MARYL ted within ompletely ond 2 st				V. Hanks	. /	ST		15 MOTHER'S A	Bes		A. Špi		LAST	
be executed and control on and control on and control on the contr		VAS DECEASED EVER IN L YES, NO OR UNKNOWN) (IF YES		MED FORCES?	215		2251	17 INFORMANI MEMO	RIAL F	HOSP I	TAL	RESS		
fificate physician poperium paperium pa		18 CAUSE OF DEATH (E. PART I. DEATH WAS (y one couse per 9 8Y: E C AUSE (b)	r line for (o), (by ond	trial	lan fil	hilla	机			BETWEEN	MATE INTERVAL DNSET AND DEATH
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 2120 ING PHYSICIAN: The low requirement of the property of the executed within 24 hours of other days can be seen signified by the property physician and completely filled in by as the building physician and completely filled in by as the building physician for minimal physician prior to the property of the and Mental Bygene prior to the plant traumattic event, the medical examples the managed or them.		Conditions, if ony, wh gove rise to immedicuse (o), stating underlying couse la	ote the ost.	(c)	R AS A CON	SEQUEN	AL NCE OF	NOT RELATED TO	O THE TERMI	INAL DISE	ASE OR COL	VDITION G	IVEN IN PART \	
At RECORDS, The low required. The low required is to be a signature of the state of	CERTIFICATION	190 DATE OF OPERATION	j	196 COND	ITION FOR W			I WAS PERFORA	AED	200 AL	ITOPSY?	20b. IF YI IN CERT	ES, WERE FINDIN	IGS USED
//SION OF VII	MEDICAL CE	216, ACCIDENT WAS UNDERLY OR CONTRIBUTING CAUSE (IF EITHER NOTIFY MEDICAL E) 216 INJURY OCCURRED WHILE NOT WHILE	E OF DEAT	P. 21e PLACE			19	211 LOCATION STREET		ED (ENTER	CITY OR T		PART I OR PART 2)	STATE
ATTEND aspital a CTOR. A differ use of Heal		220. I certify that (I) (this saw the deceased of above, (I) (we) (did) (live on_	14/14		from		that in (my) (o	19 8 5 ur) opinion d	, to	rred on the o	//y late and ho	ur and from the c	Maritim
TO HOSPITAL OR retained by the ho TO FUNERAL DIRE should be detecthed with the Store Deprivation of the transfer of the transf		724 PHYSICIAN'S HAME	TER	HALMOS	N S		r	ATT PH 22e ADDRESS	YSICIAN DE		OR PHYSI	CIAN 🗌	IMB MD	21502
BP		Burial, cremation, rem	IOVAL	23b. DATE 12-16-	- 1985			METERY OR CRI Memorial	EMATORY	23d. LO	CATION ITY OR TOWN UMber]		Allegany	STATE
DHMH - 16 60M 7/84 (VRA 15, 4)	24 Ft	James F. So	carp	elli, (Cumber	land	, MD	21502	250 DATE			250 REGIS	IBAR'S SIGNATI	

A CONTRACTOR

STATE OF MARYLAND FOR - STATE REGISTRAR REG. NO 345142 I. DECEASED NAME 20 DATE KNOWN W MONTH DAY 7b. HOUR (TYPE OR PRINT) OF ESTI-Heagle Jeannette Marie DEATH MATED 12-01 85 08:37a YEAR 1. RACE DAY 3. SEX 6 AGE (IN YEARS IF UNDER 1 YR. IF UNDER 24 HRS DATE LAST BIRTHDAY) PRONOUNCED . 85 03 female white 1948 06 DEAD 7b. CITIZEN OF WHAT COUNTR 9. BALTIMORE CITY OR COUNTY OF DEATH 70 BIRTHPLACE MARRIEDE NEVER MARRIED FOREIGN COUNTRY) GERMANY DIVORCED WIDOWED AT LEGANY 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION ID. CITY OR TOWN OF DEATH 120 USUAL OCCUPATION (TYPE OF WORK 12b. KIND OF BUSINESS OR INDUSTRY FOR MOST OF WORKING LIFE) Cumberland Sacred Heart Hospital HOUSE WIFE USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS CUMBERT AND YES [Maryland 14. FATHER'S NAME 15. MOTHER'S MAIDEN NAME LAST MIDDLE FIRST UNKNOWN BARTCZAK JADWTGA 17. INFORMANT ADDRESS 160. WAS DECEASED EVER IN U.S. ARMED FORCES? 166 SOCIAL SECURITY NO (YES. NO. OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO 30409773 MTCHAEL. McGTLL DRIVE 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o' DUE TO, OR AS A CONSEQUENCE OF BURIAL - TRANSIT HAND MENTAL HY Conditions, if ony, which gave rise to immediate cause (a) stating the under-DUE TO, OR lying cause last PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIRUTING TO DEATH RUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 ED AS A E CERTIFICATION 190. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 28 AUTOPSY2 ARDED TO THE AGE 3 SHOULD BE US ATE DEPARTMENT O YES 210 EXTERNAL CAUSE WAS 21b. TIME OF INJURY 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) HOUR A.M. MONTH DAY YEAR OR UNDERLYING CONTRIBUTING CAUSE OF DEATH 71d INJURY OCCURRED 21e PLACE OF INJURY (AT HOME 211 LOCATION STREET, FACTORY, FARM, ETC.) CITY OR TOWN COUNTY STATE NOT WHILE AT WORK GE 4 SHOULD BE FORWARD FUNERAL DIRECTOR: PAGE FER DEATH, WITH THE STATE AT WORK 220 I certify that I took charge of the remains described above, held on Autapsy Inspection ond in my opinion Notural couses deoth resulted from: Hamicide Undetermined manner ACTUAL SIGNATURE EXAMINER'S NAME AFTER I (TYPE OR PRINT) 0 23a BURIAL, CREMATION, REMOVAL 23b. DATE 23c. NAME OF CEMETERY OR 2 1985 rosedale cremAtory MARTINSBURG BERKELEY W.VA. CREMATION BP 24 FUNERAL DIRECTOR **DHMH - 17** ADDRESS SILCOX-MERRITT (VR A15 ME (5) FUNERAL SERVICE CUMBERLAND 20M 4/82

COLUMN TO SERVICE Journal Sarie Marine in the same of the

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201	TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificals he executed within 24 hours after death. Prefaired by the haspital ar attending physician.	TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physical and amought fund in by the funeral d should be detached for use as the burial-transit permit. Then please remove carbonpapes is the second and befiled within 72 hawith the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	or them 18 shows one injury or other troumotic event
DIVISION OF VITAL	TO HOSPITAL OR ATTENDING PHYSICIAN: The I retained by the haspital ar attending physician.	TO FUNERAL DIRECTOR: After this certificate he should be detached for use as the burial-transit p with the State Dept. of Health and Mental Hygien	IADODIANT. If them 21 is marked or them 18 show

003088	1-	FOR GREEN	E STR	EET	DEPART	MENT OF H	E OF MARYLAND EALTH AND MENTAL H' ICATE OF DEATH	O ~	3	2 3	- 3
	1 050	REGISTRAR CUM			1592		AST	In our or	REG. NO.		
o me		OR PRINT)	FIRST		WIDDLE		ASI	2a. DATE OF L	DEATH MONTH	DAY YEAR	26 HOUR
poge 3	-		DITH		ANCES	HELI		DECEM		1985	10:30 M
4 mo	3. SE)	(4. RACE		5. DATE C	DAY YEAR	W. AGE (11.72)	RS LAST BIRTHDAY)	MONTHS DAYS	HOURS MIN.
Jis o ge	Fen	nale	M 11	White	9	Oct.	24, 1907	7:	8 _{YR}	s.	
Pod of O	7a Bil	RTHPLACE (STATE OR F	OREIGN	16 CITIZEN OF	WHAT COUNTRY	? 8	XX NEVER MARRIED	9 BALTIMOR	ECITY OR COU	NTY OF DEATH	
depth depth	Wes	st Virginia	1	U.S.A	١.	WIDOWE			ANY COU	NTY	MD.
2 54 5		TY OR TOWN OF DEA		11. NAME OF I	HOSPITAL, NURS	ING HOME	OR OTHER INSTITUTION	12a USUAL O	CCUPATION OR MOST OF WORKIN	126. KIND O	F BUSINESS OR
s of	Cun	nberland			D HEART		AL			mcelle Co	elanese
be in	USUA	AL RESIDENCE (IF NURSI	NG HOME OR		GIVE RESIDENCE BEFO		124 INCIDE CITY HINTED		DDRESS / ZIP C		
2 11 10		ryland	Alle		Cumber		13d. INSIDE CITY LIMITS?	316 Wa	shinator	Street	/ 21502
祖 國 二		THER'S NAME				una	15 MOTHER'S MAIDEN N				
1 7994		Frederick		WIDDLE	Murray	,	Hattie		MIDDLE	Dix	r
4	16a V	VAS DECEASED EVER		MED FORCES?	166 SOCIAL SEC		17 INFORMANT		ADDRESS		
1. 22. 1	()	NO OR UNKNOWN)	(IF YES, GIV	E WAR OR DATES)	214-07-	5657A	John Helker	-Address	same as	#13 abo	ve.
RATTENDING PHYSICIAN: The low requires that the death certifical haspital or othending physician. RECTOR, After this certificate has been signed by the attending phyhed far use as the burial-transit permit. Then please remave carbon paper, at Health and Mental Hygiene prior to burial, cremation, or remavered is marked or Item 18 shows any injury, ar other traumatic event tem 21 is marked or Item 18 shows any injury, ar other traumatic event	MEDICAL CERTIFICATION	Conditions, if any, gave rise to imm couse (a), statin underlying cause PART 2 OTHER SIGN 19a DATE OF OPERAT 21a. ACCIDENT WAS UND OR CONTRIBUTING COURT CHE SIGN WHILE WHILE COURT WAS UND OR CONTRIBUTING COURT CHE SIGN WHILE COURT WAS UND OR CONTRIBUTING COURT CHE SIGN COURT C	which lediote g the last. IFICANT CO. ION ERLYING	DUE TO, O DUE TO, O DUE TO, O CONDITIONS CO 19b. CONDI 21b. TIME O HOUR A. P. 21e. PLACE	R AS A CONSEON R AS A CONSEON THE SEN THE SEN	JENCE OF JENCE OF DEATH BUT H OPERATIO DAY YEAR 19	ARTERY NOT RELATED TO THE TEL N WAS PERFORMED 216. HOW INJURY OCCU	OCC LINS RMINAL DISEASE 200 AUTOR YES	OR CONDITION SY? 20b. IF IN CE	GIVEN IN PART 110 YES, WERE FINDIN RTIFYING CAUSES YES	hrs
TO HOSPITAL OR ATTENDIN retained by the hospital or TO FUNERAL DIRECTOR. At should be detached for use o with the State Dept. of Health IMPORTANT: If them 21 is man		22a. I certify that (1) saw the decease oboyes (1) (we) (d 22b. SIGNATURE 22d. PHYSICIAN'S NA Paul Liv	d alive an id) (did no	od, M.D.	after death 19	85 , a	27e ADDRESS BMG 912 S	MEDICAL DIRECTOR SETON DR	STAFF PHYSICIAN	hour and from the	SIGNED 28-85
	- (URIAL, CREMATION,	REMOVAL				EMETERY OR CREMATOR	CITY O	RIOWN	COUNTY	STATE
BP	Bu	rial		12-30-			st Burial Pa			llegany C	
DHMH - 16 60M 7/84 (VRA 15, 4)	24 FL	O2 Greene	eorge Stree	e-Upchur et-Cumbe	ch Funer rland, M	al Hor larylar	ne, P.A. 250 D	EC 31 1		GISTRAR'S SIGNAT	

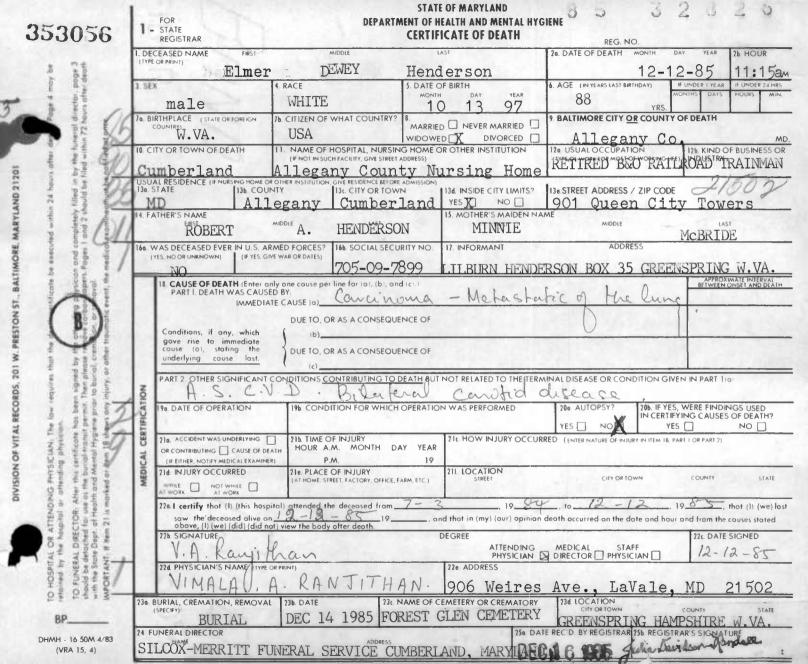
DO 912 SETON GRIVE, CLASSIANOMO 21502

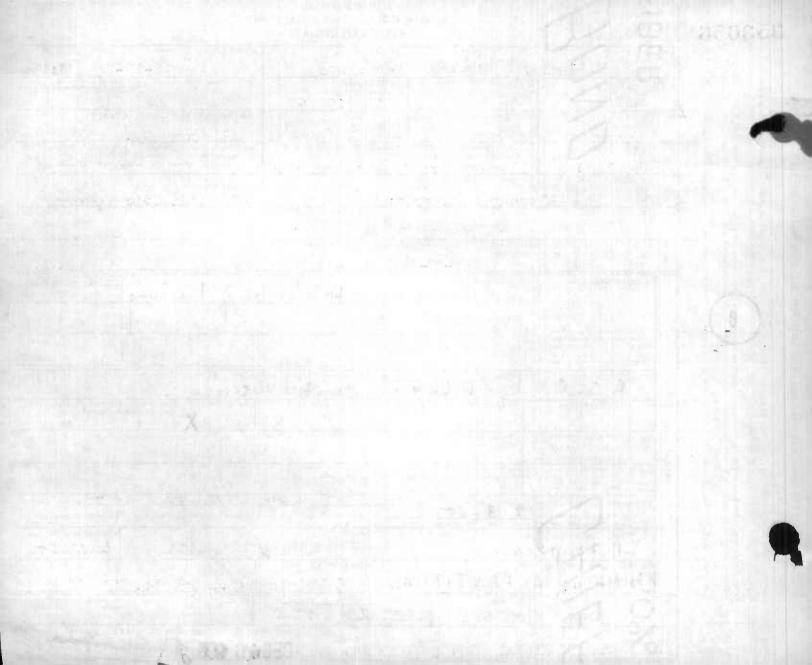
10:30 4

~~~ 105 Y 120=114

| deot                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |               | OR PRINT) FOSTE                                                                                                                                          | d, MD 21502<br>er S.                                                                                                 | Helmic                        | KST                                                         | December                        |                                                     | 2b. HOUR<br>12:307                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------|---------------------------------|-----------------------------------------------------|----------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 3. SEX        |                                                                                                                                                          | 4 RACE                                                                                                               | S. DATE O                     |                                                             | 6 AGE (IN YEARS LAST BIRT       | HDAY) IF UNDER 1 YEAR                               |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | male                                                                                                                                                     | white                                                                                                                | 0                             | 7-14-1910                                                   | 75                              | YRS                                                 | 3 FIGURS MIN                                 |
| 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |               | OUNTRY) WV                                                                                                                                               | 76 CITIZEN OF WHAT COULD                                                                                             | MTRY? 8.<br>MARRIEL<br>WIDOWE | NEVER MARRIED DIVORCED                                      | 9 BALTIMORE CITY OF<br>Allegany | County of DEATH                                     | N                                            |
| 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1             | TY OR TOWN OF DEATH                                                                                                                                      | 11. NAME OF HOSPITAL, N<br>(# NOT IN SUCH FACILITY, GIVE                                                             |                               | R OTHER INSTITUTION                                         | 12a USUAL OCCUPATIO             | WORKING LIFET INDUSTR                               | OF BUSINESS C                                |
| 30                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1             | Cumberland                                                                                                                                               | Sacred Heart                                                                                                         |                               |                                                             | ret. eng                        | ineer   rai                                         | lroad                                        |
| 35                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 13a S         | Md All                                                                                                                                                   | NTY 13c CITY OF                                                                                                      |                               | 13d. INSIDE CITY LIMITS? YES NO                             |                                 | zip code<br>town Road/2                             | 21502                                        |
| 1//                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 14. FA        | THER'S NAME<br>Sherwood He                                                                                                                               | elmick                                                                                                               | .51                           | 15 MOTHER'S MAIDEN NA                                       | ME<br>Harper                    |                                                     | LAST                                         |
| 10/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |               | AS DECEASED EVER IN U.S. AR                                                                                                                              |                                                                                                                      | L SECURITY NO.                | 17. INFORMANT                                               | ADDRE:                          |                                                     |                                              |
| 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |               | no                                                                                                                                                       | 2320                                                                                                                 | 32405                         | Mrs. Bridget                                                | Spielman-H                      | ,                                                   | MD<br>DXIMATE INTERVAL<br>IN ONSET AND DEATI |
| al, cremotian, or reming of the control of the cont |               | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                            | DUE TO, OR AS A CON  (b)  DUE TO, OR AS A CON  (c)                                                                   | pirate                        | - Preuma                                                    | ve<br>str                       | 12                                                  | 3                                            |
| or to burn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | NOI           | PART 2. OTHER SIGNIFICANT                                                                                                                                | Dihone. a                                                                                                            | lente ll                      | ming Tract                                                  | Infection . o                   | yene Fram                                           | syndre                                       |
| 34                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | CERTIFICATION | 190 DATE OF OPERATION                                                                                                                                    | 196 CONDITION FOR V                                                                                                  | VHICH OPERATION               | N WAS GERFORMED                                             | YES NO                          | 206. IF YES, WERE FIND<br>IN CERTIFYING CAUS<br>YES | DINGS USED<br>ES OF DEATH?                   |
| 0/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |               | 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEA                                                                                                |                                                                                                                      | H DAY YEAR                    | 21c HOW INJURY OCCUR                                        | RED (ENTER NATURE OF INJUR      | Y IN ITEM 18 PART 1 OR PART 2                       | )                                            |
| hem-18 show                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | CAL           | (IF EITHER, NOTIFY MEDICAL EXAMINE                                                                                                                       |                                                                                                                      | 17                            |                                                             |                                 |                                                     |                                              |
| orked or Hem 18 -ho-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | MEDICAL       | (IF EITHER, NOTIFY MEDICAL EXAMINES 21d. INJURY OCCURRED  WHILE NOT WHILE AT WORK                                                                        | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, C                                                                  |                               | 21f. LOCATION<br>STREET                                     | CITY OR TOV                     | vn county                                           | STATE                                        |
| of Recith and Mental Hygien<br>n 21 is morked of them 18 than                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | MEDICAL       | 21d. INJURY OCCURRED  WHILE NOT WHILE AT WORK  22a.1 certify that (1) (this hasp- sow the deceased alive an above, (1) (well Idial) Idial an             | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, C                                                                  | OFFICE, FARM, ETC.)  from     | d that in (my) (our) opinion                                | _, to12/1                       | 2/8 1987                                            | _, that (i) ( <del>ij a)</del> (             |
| them 21 is morked or them.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | MEDICAL       | 21d. INJURY OCCURRED  WHILE NOT WHILE AL WORK  22a.1 certify that (I) (this hasp sow the deceased alive an above, (I) (we) (did 1) did no 22b. SIGNATURE | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, of ital) offended the deceosed 2011 view the body offer death.        | OFFICE, FARM, ETC.)  from     | d that in (my) (our) opinion opegree                        | _, to12/1                       | 19 Tom the band hour and from the 22c. DA           | _, that (i) ( <del>ij e)  </del>             |
| with the State Dept of Health and Mental Hygien IMPORTANT: If them 21 is marked or them 18 ha                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | MEDICAL       | 21d. INJURY OCCURRED  WHILE NOT WHILE AT WORK  22a.1 certify that (1) (this hasp- sow the deceased alive an above, (1) (well Idial) Idial ac             | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, of ital) offended the deceosed 22 11 15 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 | OFFICE, FARM, ETC.)  from     | d that in (my) (our) opinion opegree  ATTENDING PHYSICIAN E | to                              | 19 To the bnd hour and from H                       | that (I) (wold the couses stated TE SIGNED   |

COLUMN CONTROL OF AUGUST AND AUGU Foscor S. Helinick Allegany County, 232032405 ( of Team Manage, Prophisms, 10 21532 





FOR STATE

STATE OF MARYLAND

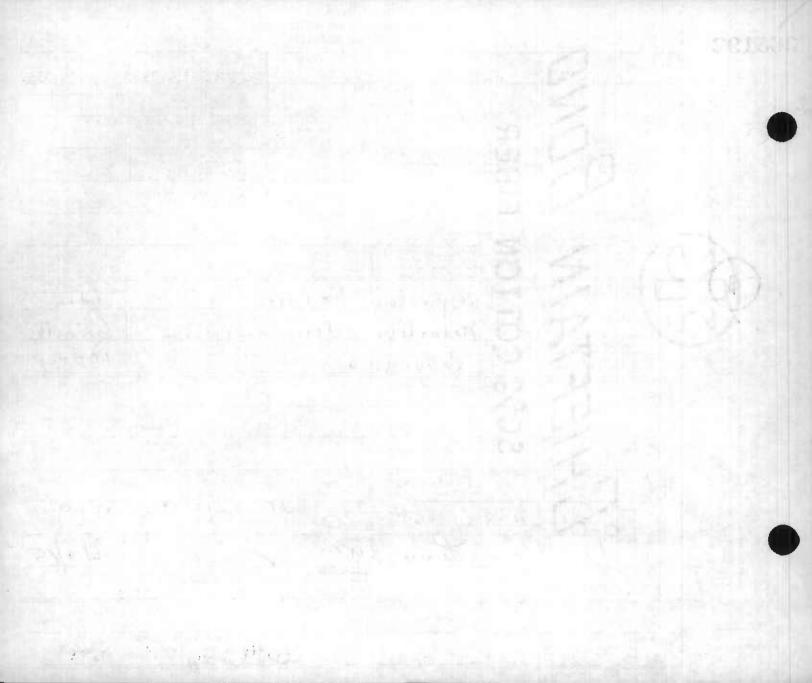
James F. Scarpelli, Cumberland, MD 21502

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

| REGISTRAR                                                              |                |                        |                                                   | CERTIFIC  | CATE OF DUAL                         | REG                                               | . NO.                |                                           |                                      |
|------------------------------------------------------------------------|----------------|------------------------|---------------------------------------------------|-----------|--------------------------------------|---------------------------------------------------|----------------------|-------------------------------------------|--------------------------------------|
| DECEASED NAME                                                          | FIRST          | ٨                      | AIDDLE                                            | L         | AST                                  | 20. DATE OF DEATI                                 | H MONTH              | DAY YEAR                                  | 2b HOUR                              |
|                                                                        | MMA            | JOS                    | SEPHINE                                           | HER       | NDON                                 | DECEMBER                                          |                      |                                           | 10:35A                               |
| 1. SEX                                                                 | 4              | RACE                   |                                                   | 5. DATE O |                                      | 6 AGE (IN YEARS LAS                               | T BIRTHDAY)          | MONTHS DAYS                               |                                      |
| female                                                                 | -              | white                  |                                                   |           | 5-16-1926                            | 59                                                | YRS                  |                                           |                                      |
| BIRTHPLACE (STATE OR I                                                 | OREIGN 76      | CITIZEN OF             | WHAT COUNTRY?                                     | 8.        | NEVER MARRIED                        | 9. BALTIMORE CIT                                  | Y OR COUN            | ITY OF DEATH                              |                                      |
| WV                                                                     | 1              | USA                    |                                                   | WIDOWE    |                                      | All                                               | Legany               |                                           | MD                                   |
| IO CITY OR TOWN OF DEA                                                 |                |                        | HOSPITAL, NURSIN<br>HEACHITY GIVESTREE<br>HOSPITA |           | PR OTHER INSTITUTION                 | 120 USUAL OCCUP<br>LTYPE OF WORK FOR MC<br>NOUSEW |                      | 12b. KIND<br>INDUSTRY<br>OWI              | n home                               |
| USUAL RESIDENCE (IF NURS                                               | 13b. COUNTY    | egany                  | GIVE RESIDENCE BEFORE 13c. CITY OR TOWN 01dtow    |           | 13d INSIDE CITY LIMITS?<br>YES NO XX | 13e STREET ADDRE<br>Route                         | ss / zip co<br>I Box | DE<br>409/215                             | 55                                   |
| 14 FATHER'S NAME<br>FIRST                                              | illiam         | Clinto                 | on Kniight                                        |           | 15. MOTHER'S MAIDEN NAME FIRST Anna  | Wickline                                          |                      | l.                                        | AST                                  |
| 160 WAS DECEASED EVER                                                  | IN U.S. ARMI   | D FORCES?              | 16b SOCIAL SECU                                   | RITY NO.  | 17. INFORMANT                        |                                                   | DRESS                |                                           |                                      |
| NO OK ONKNOWN)                                                         | (IN JES CIAE A | VAR OR DATES           | 235-36-1                                          | 040       | Mrs. Arnett                          | D. Hernd                                          | on, 01               | dtown, I                                  | MD - wife                            |
| 18 CAUSE OF DEAT                                                       | H (Enter anly  | ane cause per          |                                                   |           | 01                                   |                                                   |                      | APPRO<br>BETWEET                          | XIMATE INTERVAL<br>N ONSET AND DEATH |
| PART I. DEATH W                                                        | MAS CAUSED     |                        | Respire                                           | story     | 1 tailuu                             |                                                   | 0.00                 | 1                                         | day                                  |
| I To Bridge of                                                         |                | 2 /                    | R AS A CONSEQUE                                   | INCE OF   |                                      |                                                   |                      | 1                                         | 10                                   |
| Canditians, if any                                                     |                | ( b)_                  | Metas                                             | 12 Oc     | adenoc                               | ercino                                            | não                  | 6                                         | marelys                              |
| gave rise to im-<br>cause (a), statin<br>underlying cause              | ng the         | DUE TO, OI             | RAS PONSEQUE                                      | MCE OF    | uĝ                                   | 1991                                              |                      | (0                                        | doup                                 |
|                                                                        | NIFICANT CO    | NDITIONS CO            | ONTRIBUTING TO E                                  | DEATH BUT | NOT RELATED TO THE TERM              | INAL DISEASE OR C                                 | ONDITION             | GIVEN IN PART                             | lia                                  |
| 190 DATE OF OPERA                                                      | TION           | 19b. COND              | TION FOR WHICH                                    | OPERATIO  | N WAS PERFORMED                      | 200 AUTOPSY? YES NO[                              | IN CE                | YES, WERE FINE<br>RTIFYING CAUSI<br>YES [ |                                      |
| OR CONTRIBUTION                                                        | CAUSE OF DEATH | 21b. TIME O<br>HOUR A. | M. MONTH DA                                       | AY YEAR   | 21c. HOW INJURY OCCUR                | RED (ENTER NATURE OF                              | INJURY IN ITEM       | 18 PART I OR PART 2                       |                                      |
| (IF EITHER NOTIFY MEDI                                                 | RED            | 21e. PLACE             |                                                   | - 1111    | 211 LOCATION<br>STREET               | CITY                                              | OR TOWN              | COUNTY                                    | STATE                                |
| 220. I certify that (1) saw the decease abave (1)(we) (22b. SIGNATURE) |                |                        |                                                   |           | nd that in (my) (aur) apinian        | , 10                                              | ne date and l        | naur and fram th                          | e causes stated                      |
| C                                                                      | Jul            | lan                    | Jam                                               | ul        | ATTENDING PHYSICIAN                  | DIRECTOR   PH                                     | STAFF<br>YSICIAN [   | 12                                        | 119/15                               |
| DR. LAMM                                                               |                | RIN1)                  |                                                   |           | MEMORIAL HOS<br>CUMBERLAND           |                                                   |                      | BUILDIN                                   | G                                    |
| 230 BURIAL, CREMATION,                                                 | REMOVAL        | 23b. DATE              | 23c 1                                             | NAME OF C | EMETERY OR CREMATORY                 | 23d LOCATION                                      |                      | COUNTY                                    | STATE                                |
| Burial                                                                 |                | 12-22                  | -1985 0                                           | ldtow     | n Veterans Ce                        | m. Oldt                                           |                      | llegany                                   | MD                                   |
| 24 FUNERAL DIRECTOR                                                    |                |                        | ADDRESS                                           |           |                                      | E REC'D. BY REGIST                                | RAR 25b REC          | ISTRAR'S SIGN                             | ATURE                                |

DHMH - 16 60M 7/B4 (VRA 15, 4)

TO FUNERAL DIRECTOR



## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

| L  | REGISTRAR                                                            |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                           | REG                    | . NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              |                                  |
|----|----------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|----------------------------------|
| I  | DECEASED NAME FIRST                                                  | WIDDLE                            | LAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1232                      | 20 DATE OF DEATH       | MONTH DAY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | YEAR         | 26 HOUR                          |
| L  | HOWAF                                                                |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | RICK                      |                        | 19, 198                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              | 2:50<br>p M                      |
| P  | SEX 11 A                                                             | 4. RACE                           | 5. DATE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                           | 6 AGE (IN YEARS LAS    | T BIRTHDAY) IF U                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | INDER I YEAR | IF UNDER 24 HRS                  |
| L  | Male                                                                 | White                             | MONTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2/10/1913                 | 72                     | YRS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |              | HOURS MIN.                       |
| 7  | a. BIRTHPLACE (STATE OR FOREIGN                                      | 76 CITIZEN OF WHAT COUN           | MARRIED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | NEVER MARRIED             | 9 BALTIMORE CIT        | Y OR COUNTY OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | DEATH        |                                  |
| 4  | Maryland                                                             | USA                               | WIDOWED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                           |                        | Hegany                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |              | MD                               |
| 有  | O CITY OR TOWN OF DEATH                                              | 11. NAME OF HOSPITAL, N           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OTHER INSTITUTION         | 126. USUAL OCCUP       | ATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              | OF BUSINESS OR                   |
| ¥. | Cumberland                                                           | (IF NOT IN SUCH FACILITY, GIVE    | orial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                           | Construct              | ALC: NO STATE OF THE PARTY OF T | INDUSTRY     | ads                              |
| 1  | USUAL RESIDENCE (IF NURSING HOME                                     |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                           |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              | aus                              |
|    | laryland   136 COU                                                   |                                   | • 17                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 34 INSIDE CITY LIMITS?    | Star Rout              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 5F           | 21536                            |
| Ŧ  | 4 FATHER'S NAME                                                      | uspare 146                        | 1:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | MOTHER'S MAIDEN           | AME                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              |                                  |
| Ĭ  | Joseph                                                               | MIDDLE LAS                        | trick                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Armint                    | MIDDI                  | E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | D.           |                                  |
| 1  | 60 WAS DECEASED EVER IN U.S. A                                       |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 7. INFORMANT              |                        | DRESS - D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |              | utler                            |
| 1  | ES NOOR UNKNOWN) (IF YES, O                                          | SIVE WAR OR DATES) 201-0          | 01-8086 N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | fra Eth-1 )               | f 17.4 1               | Star Rou                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ite,         | 35F                              |
| 1  |                                                                      |                                   | ĮĮ.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Mrs. Ethel M              | 1. Hetrick             | Grantsvi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |                                  |
| П  | PART I. DEATH WAS CAUS                                               | only one cause per the far (a), ( | // 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                           |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | BOYEEN       | MATE INTERVAL<br>ONSET AND DEATH |
| П  |                                                                      | ATE CAUSE (a) GAN                 | to ament                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | J                         |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OW           | unescate                         |
| 1  |                                                                      | DUE TO, ORAS A CONS               | SEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                           |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1            |                                  |
| L  | Canditions, if ony, which                                            |                                   | onus                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                           |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | U            | Maroun                           |
| ı  | gove rise to immediate cause (a), stating the underlying cause last. | DUE TO, ORAS A CONS               | SEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | elvallascus               | 20.0                   | A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |              | LL                               |
| L  |                                                                      | (c)                               | Tiller                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                           |                        | W)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                                  |
| ı  |                                                                      | CONDITIONS CONTRIBUTING           | G TO DEATH BUT N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | OT RELATED TO THE TER     | RMINAL DISEASE OR C    | ONDITION GIVEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | IN PART 1    | a                                |
| 4  | 190 DATE OF OPERATION  210 ACCIDENT WAS UNDERLYING                   |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                           |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              |                                  |
| L  | 190 DATE OF OPERATION                                                | 196 CONDITION FOR W               | HICH OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | WAS PERFORMED             | 200 AUTOPSY2           | 20b. IF YES, W                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |              |                                  |
|    | # 10/4                                                               | 2                                 | A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                           | YE NO                  | YES L                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              | NO 🗆                             |
| 1  |                                                                      | LIGUE A M. MONITI                 | L DAY VEAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 21c HOW INJURY OCCU       | JRRED (ENTER NATURE OF | NJURY IN ITEM 18 PART                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | OR PART 2)   |                                  |
| П  | OR CONTRIBUTING CAUSE OF D                                           | CAIN                              | 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                           |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              |                                  |
| П  | LIF EITHER NOTIFY MEDICAL EXAMIN  21d INJURY OCCURRED                | 21e. PLACE OF INJURY              | 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | II LOCATION               |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              |                                  |
| ı  | WHILE NOT WHILE                                                      | (AT HOME, STREET, FACTORY, O      | OFFICE FARM, ETC )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET                    | CITY O                 | RTOWN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | COUNTY       | STATE                            |
| П  | AT WORK AT WORK                                                      | pital) attended the deceased f    | 17000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Jog A 10 125              | R. Mari                | 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 86           |                                  |
| П  | saw the deceased alive o                                             | 10 100                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | that in (my) (our) opinio | n death accurred on th | e date and hour as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | d from the   | that (I) (we) last               |
| П  | abave, (1) (we) (did) (did n<br>22b, SIGNATURE                       | not) view the bady attendeath     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                           |                        | . date one noor an                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                                  |
| П  | 20. SIGNATURE                                                        | 2.2.00                            | W ,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | GREE ATTENDING            | MEDICAL S              | TAFF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 22c. DATE    | SIGNED                           |
| 1  | 1                                                                    | waysu                             | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | PHYSICIAN                 | DIRECTOR   PHY         | SICIAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 112          | 19181                            |
| 1  | 226 PHYSICIAN'S NAME (TYPE                                           | OR PRINT)                         | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 22e ADDRESS 500           | Memorial A             | ve., Mem                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | orial        | MEd. B1                          |
| 1  | Dr. Diener                                                           |                                   | 200                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Cum                       | berland, MI            | 21502                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              |                                  |
| 2  | 30 BURIAL, CREMATION, REMOVA                                         | AL 23b. DATE                      | 23c. NAME OF CEM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | METERY OR CREMATORY       |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              |                                  |
| 1  | (SPECIFY) Burial                                                     | 12/22/1985                        | No. of the last of | 11e Cemeter               | (AT Licitize           | sville,G                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | arret        | STATE                            |
|    |                                                                      |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                           |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              |                                  |

DHMH - 16 60M 7/84 (VRA 15, 4)

TO FUNERAL DIRECTOR

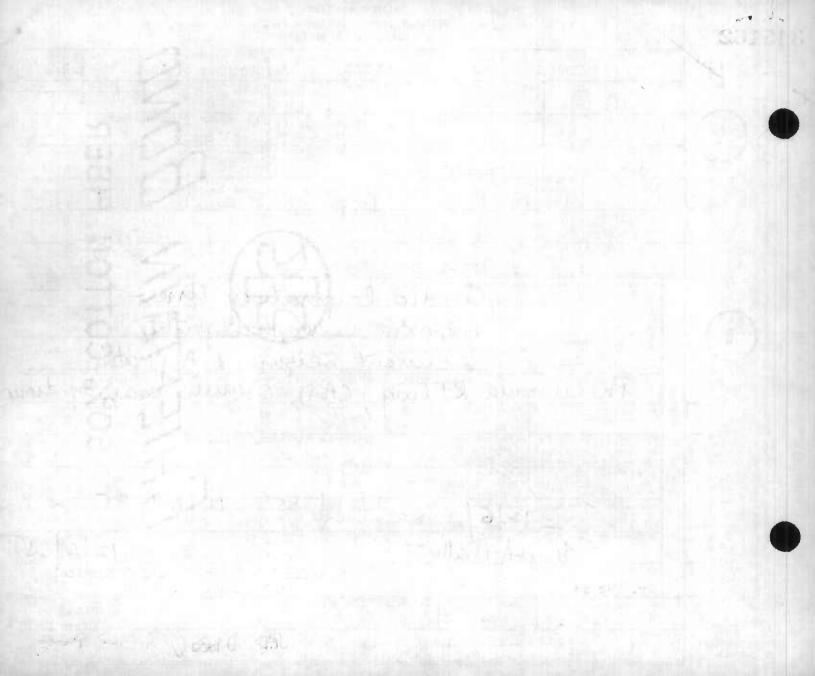
14 FAINERAL PRECTOR

Grantsville, MD

250. DATE REC'D. BY REGISTRAR 250 HEDSTRAR'S SIGNATURE

230 Baltimore Ave. Cumberland, MD 21502

(VRA 15, 4)



| 008007                                                                                                                                                                                                | 1             | FOR<br>STATE<br>REGISTRAR                                                                                                        |                                     | DEPA                    |               | EALTH AND MENTAL HYG<br>ICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | IENE 8 5                                                 | ئ<br>40.              | 2 0                                  | <b>3</b> U                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-----------------------|--------------------------------------|----------------------------------------------------|
| age 4 may be ector, page 3 s after death noce.                                                                                                                                                        | J. DE         | CEASED NAME FRST Nollie  X Female                                                                                                | 4 RACE White                        | MIDDLE                  | HOCK          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 26. DATE OF DEATH  6. AGE (IN YEARS LAST BIR             |                       | 7 85<br>F UNDER 1 YEAR<br>ONTHS DAYS | 2b. HOUR<br>5 15 P<br>IF UNDER 24 HRS<br>HOURS MIN |
| deam. Pe                                                                                                                                                                                              |               | IRTHPLACE ISTATE OR FOREIGN Maryland                                                                                             | TE CITIZEN OF                       | WHAT COUNT              | PY2 B         | NEVER MARRIED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | BALTIMORE CITY                                           | OR COUNTY             | OF DEATH                             | M                                                  |
| by the fu                                                                                                                                                                                             |               | TY OR TOWN OF DEATH Frostburg                                                                                                    | Frost                               | urg Vil                 | lage Nu       | rother Institution rsing Home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 12a. USUAL OCCUPAT<br>(TYPE OF WORK FOR MOST:<br>Retired |                       | Pract                                | of Business o                                      |
| hin 24 ho<br>filled in<br>build be fill<br>miner mu                                                                                                                                                   | 130           | AL RESIDENCE (IF NURSING HOME OF STATE 136 COU                                                                                   | ROTHERINSTITUTION<br>INTY<br>Legany | 13c. CITY OR T<br>Cumbe | OWN           | 131 INSIDE CITY LIMITS?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 134 STREET ADDRESS<br>114 South                          |                       |                                      | 2150                                               |
| ompletely and 2 sho                                                                                                                                                                                   | 14 F          | ATHER'S NAME<br>Elwood Cra                                                                                                       | abtree                              | LAST                    |               | IS MOTHER'S MAIDEN NAME FIRST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | a Platt                                                  |                       | LA                                   | ST                                                 |
| an and co                                                                                                                                                                                             | 160           | WAS DECEASED EVER IN U.S. A<br>YES, NO ORUNKNOWN] (IF YES, GI                                                                    | RMED FORCES?<br>VE WAR OR DATES]    | 166 SOCIAL SI<br>214-0  | 5-5002        | Mr. Edwin L                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | . Hockman,                                               |                       | ale Va                               | Son                                                |
| the control of                                                                                                                                                                                        |               | IB CAUSE OF DEATH (Enter of PART I. DEATH WAS CAUS IMMEDIA  Conditions, if only, which gove rise to immediate                    | TE CAUSE (a)                        | CARLONSE                | uao           | aneker                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | mentio                                                   | 'n                    | SETWEEN                              | (MATE INTERVAL<br>ONSET AND DEAT                   |
| less requires than<br>been signed by the<br>c. Then please rec<br>rior to burist, ere<br>s any enjary, et o                                                                                           | NOIL          | couse (a), stating the underlying couse last.  PART 2 OTHER SIGNIFICANT                                                          |                                     | ONTRIBUTING             |               | NOT RELATED THE ERM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | INAL DISEA FOR COM                                       |                       | 4                                    |                                                    |
| nn.<br>cate has t<br>it permit.<br>rgiene pr                                                                                                                                                          | CERTIFICATION |                                                                                                                                  |                                     |                         | ICH OPERATION |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | YES NO                                                   | IN CERTIFY<br>YES     |                                      | NO [                                               |
| PHYSICIAN ng physician. this certificat urial-transit p Mental Hygie                                                                                                                                  | MEDICAL CI    | 21g. ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING [ OR CAUSE OF DE (IF EITHER, NOTIFY MEDICAL EXAMINES  216 INJURY OCCURRED         | HOUR A                              | .M. MONTH               | DAY YEAR      | 21c HOW INJURY OCCURR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ED (ENTER NATURE OF INJU                                 | JRY IN ITEM 18, PAI   | T 1 OR PART 2)                       |                                                    |
| OR ATTENDING toppital or the second toppital or the second toppital or attending them 21 is market is market. | MEI           | WHILE AT WORK AT WORK 220 I certify that (I) (this hasp saw the deceased alive or obove, (I) (we) (did) (did in 22b. SIGNAT III) | (AT HOME, ST                        | ne deceased fro         | m X/A         | d that in (my) (aur) apinion of the control of the |                                                          | J) 1<br>date and hour | ond from the                         |                                                    |
| TO HOSPITAL. Tetained by the N TO FUNERALE should be detech with the State D IMPORTANT: II                                                                                                            | 230           | BURIAL CREMATION, REMOVAL<br>SPECIFIC BURIAL                                                                                     | E, K,                               |                         | 30 NAME OF C  | 90 Must                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ST, WA                                                   | eting                 | art<br>OUNTY                         | and as                                             |
| DHMH-16 25M<br>(VRA 15, 4) 1/79                                                                                                                                                                       |               | UNERAL DIRECTOR NAME James F. S                                                                                                  |                                     | 0-1985<br>i, Cumb       |               | r Springs Cem                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | REC'D BY REGISTRAD                                       | dtown.                | Md . AR'S SIGNAT                     | TURE                                               |

G. Hartmani E.

441

h/arm

Institute described of the second of the sec

39417.400

rision . Hebr. H. River . relain

the contract of the contract of

Acres (Acres de la constitución de

sale the distance of the

X20 170

And constill them the speciment of the second of the secon

A MALON CO. S. Departmentally, 125 or any and a

| /          | 1 -                   | STATE MAIN ST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Hem 18axb 1.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                 | OF HEALTH AND MENTAL HY                                                                               | GIENE O O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 3 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 0 0                                                                              |
|------------|-----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
|            |                       | REGISTRAR LONACON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ING, MD 21                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | .539                                                                                            | RTIFICATE OF DEATH                                                                                    | REG. N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                  |
|            |                       | CEASED NAME FIRST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | MIDDLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                 | LAST                                                                                                  | 20. DATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | MONTH DAY YEA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 2b HOUR                                                                          |
|            |                       | AMANDA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | MAE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | HUG                                                                                             | HES                                                                                                   | 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | /04/1985                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                  |
|            | 3. SE                 | X                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4. RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                 | ATE OF BIRTH                                                                                          | 6. AGE (IN YEARS LAST BIR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | YEAR IF UNDER 24                                                                 |
|            | Fe                    | emale                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | White                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                 | 3/3/1909                                                                                              | 76                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | YRS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                  |
| 6          |                       | RTHPLACE (STATE OR FOREIGN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 76. CITIZEN OF WHAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | COUNTRY? 8                                                                                      | RRIED ANEVER MARRIED                                                                                  | 9 BALTIMORE CITY C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | OR COUNTY OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Н                                                                                |
|            |                       | ryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | U.S.A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                 | OWED DIVORCED                                                                                         | ALLEGANY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | COUNTY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                  |
| 0          | 10 CI                 | TY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 11. NAME OF HOSPITA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                 | ME OR OTHER INSTITUTION                                                                               | 120. USUAL OCCUPAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ND OF BUSINESS                                                                   |
| A          | -                     | nberland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | SACRED HE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | CART HOSP                                                                                       | PITAL                                                                                                 | Silk Mill                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Mat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | erial                                                                            |
| 21         |                       | AL RESIDENCE (IF NURSING HOME OF TATE 136. COU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TY OR TOWN                                                                                      | I 13d. INSIDE CITY LIMITS?                                                                            | 1130 STREET ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | / 7IP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                  |
| 20         | -                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | naconing                                                                                        | YES NO                                                                                                | 13e STREET ADDRESS<br>21 Charles                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | stown St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 21539                                                                            |
| 10         | 14 FA                 | THER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | MIDDLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | LAST                                                                                            | 15. MOTHER'S MAIDEN N                                                                                 | AME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | LAST                                                                             |
| 1          | B                     | ruce                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Colen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                 | Isabell                                                                                               | WIDDLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Johnson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | LAST                                                                             |
|            |                       | VAS DECEASED EVER IN U.S. AF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OCIAL SECURITY N                                                                                | O. 17. INFORMANT                                                                                      | ADDR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                  |
| 11         | ,                     | YES, NO OR UNKNOWN) (IF YES, GI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | VE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 3-24-7388                                                                                       | Mr. Freder                                                                                            | ick Hughes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Lonaconing                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | , Md.                                                                            |
| 1          |                       | 18 CAUSE OF DEATH (Enter o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | nly one couse per line for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (a), (b), and (c).)                                                                             |                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | APF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | PROXIMATE INTERVA                                                                |
|            |                       | 18 CAUSE OF DEATH (Enter of PART I. DEATH WAS CAUSI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | TE CAUSE (0)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | rdiac                                                                                           | arrest                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (ث                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Lhe                                                                              |
|            |                       | MMEDIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | TE CHOSE (0)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                 |                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                  |
|            |                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | D TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | CONTRACTOR                                                                                      | o r                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                  |
|            |                       | Conditions if any which                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | DUE TO, OR AS A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CONSEQUENCE                                                                                     | of artery di                                                                                          | seaso                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Vew.                                                                             |
| The second |                       | Conditions, if ony, which gove rise to immediate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (b) (c) (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | TNATY                                                                                           | artery di                                                                                             | seasco                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | year                                                                             |
|            |                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | DUE TO, OR AS A O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | TNATY                                                                                           | artery di                                                                                             | seasco                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | year                                                                             |
|            |                       | gove rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | DUE TO, OR AS A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CONSEQUENCE                                                                                     | artery di                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2<br>IDITION GIVEN IN PAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                  |
|            | NO                    | gove rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | DUE TO, OR AS A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CONSEQUENCE                                                                                     | artery di                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2<br>POLITION GIVEN IN PAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                  |
|            | ATION                 | gove rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | DUE TO, OR AS A O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | CONSEQUENCE O                                                                                   | artery di                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 20b. IF YES, WERE FIR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | RT 110                                                                           |
| 9          | TIFICATION            | gove rise to immediate cause (a), stating the underlying cause last.  PART 2 OTHER SIGNIFIC ANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | DUE TO, OR AS A O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | CONSEQUENCE O                                                                                   | OF BUT NOT RELATED TO THE TER                                                                         | MINAL DISEASE OR CON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | RT 110                                                                           |
| 9          | CERTIFICATION         | gove rise to immediate cause (a), stating the underlying cause lost.  PART 2 OTHER SIGNIFICANT  19a DATE OF OPERATION  21a. ACCIDENT WAS UNDERLYING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ONDITIONS CONTRIB                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | CONSEQUENCE OUTING TO DEATH                                                                     | OF  BUT NOT RELATED TO THE TER  ATION WAS PERFORMED  216 HOW INJURY OCCU                              | MINAL DISEASE OR CON  200. AUTOPSY?  YES \( \text{NO} \)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 20b. IF YES, WERE FIN CERTIFYING CAU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ND INGS USED USES OF DEATH                                                       |
| 9          |                       | gove rise to immediate cause (a), stating the underlying cause last.  PART 2 OTHER SIGNIFIC ANT  19a DATE OF OPERATION  21a. ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING ] CAUSE OF DE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | CONDITIONS CONTRIBUTION FOR ALL HOUR A.M. MI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | CONSEQUENCE OUTING TO DEATH                                                                     | OF  BUT NOT RELATED TO THE TER  ATION WAS PERFORMED  21c HOW INJURY OCCU                              | MINAL DISEASE OR CON  200. AUTOPSY?  YES \( \text{NO} \)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 20b. IF YES, WERE FIN CERTIFYING CAU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ND INGS USED USES OF DEATH!                                                      |
| 9          |                       | gove rise to immediate cause (a), stating the underlying cause lost.  PART 2 OTHER SIGNIFICANT  19a DATE OF OPERATION  21a. ACCIDENT WAS UNDERLYING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ONDITIONS CONTRIBUTIONS CONDITION FOR ALL ALL ALL ALL ALL ALL ALL ALL ALL AL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | CONSEQUENCE OUTING TO DEATH OR WHICH OPER. RY ONTH DAY Y                                        | OF  BUT NOT RELATED TO THE TER  ATION WAS PERFORMED  216 HOW INJURY OCCU  EAR  19  211 LOCATION       | 200 AUTOPSY?  YES NO RRED (ENTER NATURE OF INJU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 20% IF YES, WERE FIN IN CERTIFYING CAU YES THE STATE OF PARTITY OF | NDINGS USED<br>USES OF DEATH?<br>NO [                                            |
| 99         | MEDICAL CERTIFICATION | gove rise to immediate cause (a), stating the underlying cause lost.  PART 2 OTHER SIGNIFICANT  19a DATE OF OPERATION  21a. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING ] CAUSE OF DE [IF EITHER, NOTIFY MEDICAL EXAMINE 21d. INJURY OCC URRED WHILE ] NOT WHILE [INDIWHILE ]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ONDITIONS CONTRIBUTION FOR ALL HOUR A.M. MIRE OF INJURE  | CONSEQUENCE OUTING TO DEATH OR WHICH OPER. RY ONTH DAY Y                                        | OF  BUT NOT RELATED TO THE TER  ATION WAS PERFORMED  216 HOW INJURY OCCU  EAR  19  211 LOCATION       | MINAL DISEASE OR CON  200. AUTOPSY?  YES \( \text{NO} \)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 20% IF YES, WERE FIN IN CERTIFYING CAU YES THE STATE OF PARTITY OF | NDINGS USED USES OF DEATH? NO [                                                  |
| 7          |                       | gove rise to immediate cause (a), stating the underlying cause last.  PART 2 OTHER SIGNIFICANT  19a DATE OF OPERATION  21a. ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING [ OR CONTRIBUTING [ CAUSE OF DE (IF ETIMER, NOTIFY MEDICAL EXAMINE 21d. IN JURY OCC URRED AT WORK ]  NOT WHITE [ AT WORK ]  NOT WHITE [ AT WORK ]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ONDITIONS CONTRIBUTION FOR ALL HOUR A.M. MI P.A.C. 21e. PLACE OF INJUGATION ENGINEERS. FACT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | CONSEQUENCE OUTING TO DEATH OR WHICH OPER.  RY ONTH DAY Y  URY ORY, OFFICE, FARM, ETI           | OF  BUT NOT RELATED TO THE TER  ATION WAS PERFORMED  EAR 19 216 HOW INJURY OCCU STREET                | 200 AUTOPSY?  YES NO RRED (ENTER NATURE OF INJU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 20b IF YES, WERE FIN IN CERTIFYING CAU YES THE TENT OF PARTY IN ITEM 18 PART I OR PARTY IN ITEM 18 PART I OR PARTY IN ITEM 18 | NDINGS USED USES OF DEATH? NO 17 2)                                              |
| 99         |                       | gove rise to immediate cause (a), stating the underlying cause last.  PART 2 OTHER SIGNIFIC ANT  19a DATE OF OPERATION  21a, ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DE (IF EITHER NOTIFY MEDICAL EXAMINE AT WORK NOT WHILE AT WORK SOW the deceased olive of the cause of the contribution of the cause o | CONDITIONS CONTRIBUTION F.  21b. TIME OF INJUE HOUR A.M. MI P.M.  21e. PLACE OF INJU (AT HOME, STREET, FACT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | CONSEQUENCE OF WHICH OPER.  RY ONTH DAY Y  URY TORY, OFFICE, FARM, ETC.                         | OF  BUT NOT RELATED TO THE TER  ATION WAS PERFORMED  216 HOW INJURY OCCU  EAR  19  211 LOCATION       | MINAL DISEASE OR CON  206 AUTOPSY?  YES NO RED (ENTER NATURE OF INJURE)  CITY OR TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 20% IF YES, WERE FIN IN CERTIFYING CAU YES THE TENT OF PART OF | NDINGS USED USES OF DEATH NO 172)  y sta                                         |
| 99         |                       | gove rise to immediate cause (a), stoting the underlying cause lost.  PART 2 OTHER SIGNIFICANT  19a DATE OF OPERATION  21a. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DE (IF EITHER, NOTIFY MEDICAL EXAMINE AT WORK AT WORK AT WORK AT WORK AT WORK 22a. I certify that (1) (this hosp saw the deceased alive or above, (1) (we) (did) (did in above, (1) (we) (did) (did in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | CONDITIONS CONTRIBUTION F.  21b. TIME OF INJUE HOUR A.M. MI P.M.  21e. PLACE OF INJU (AT HOME, STREET, FACT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | CONSEQUENCE OF WHICH OPER.  RY ONTH DAY Y  URY TORY, OFFICE, FARM, ETC.                         | OF  BUT NOT RELATED TO THE TER  ATION WAS PERFORMED  EAR  19  216 HOW INJURY OCCU  STREET             | MINAL DISEASE OR CON  206 AUTOPSY?  YES NO RED (ENTER NATURE OF INJURE)  CITY OR TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 20b IF YES, WERE FINING CAU YES  JRY IN ITEM 18 PART 1 OR PART DWN COUNTY 19 ote and hour and from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | NDINGS USED USES OF DEATH NO 172)  Y STA'  , that (I) (we the causes state       |
| 99         |                       | gove rise to immediate cause (a), stating the underlying cause last.  PART 2 OTHER SIGNIFIC ANT  19a DATE OF OPERATION  21a, ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DE (IF EITHER NOTIFY MEDICAL EXAMINE AT WORK NOT WHILE AT WORK SOW the deceased olive of the cause of the contribution of the cause o | CONDITIONS CONTRIBUTION F.  21b. TIME OF INJUE HOUR A.M. MI P.M.  21e. PLACE OF INJU (AT HOME, STREET, FACT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | CONSEQUENCE OF WHICH OPER.  RY ONTH DAY Y  URY TORY, OFFICE, FARM, ETC.                         | EAR 19 211. LOCATION STREET  210. and that in (my) (our) opinion DEGREE  ATTENDING                    | 200. AUTOPSY? YES NO RRED (ENTER NATURE OF INJURE OF INJ | 20% IF YES, WERE FII IN CERTIFYING CAU YES  JIRY IN ITEM 18 PART 1 OR PAR OWN COUNTY  19  120. D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | NDINGS USED USES OF DEATH' NO [] 172)  y stal                                    |
| 99         |                       | gove rise to immediate cause (a), stating the underlying cause last.  PART 2 OTHER SIGNIFIC ANT  19a DATE OF OPERATION  21a. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DE (IF EITHER NOTIFY MEDICAL EXAMINE AT WORK NOT WHILE AT WORK SOW the deceased olive or above, (I) (we) (did) (did not 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | CONDITIONS CONTRIBI  196 CONDITION F.  216 TIME OF INJUR HOUR A.M. MI P.M.  21e. PLACE OF INJU (AI HOME, STREET, FACT  at) view the body after de                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | CONSEQUENCE OF WHICH OPER.  RY ONTH DAY Y  URY TORY, OFFICE, FARM, ETC.                         | EAR 19 211 LOCATION STREET  , and that in (my) (our) opinion DEGREE  ATTENDING PHYSICIAN              | MINAL DISEASE OR CON  200. AUTOPSY?  YES NO CITY OR TO  1 deoth occurred on the divided in the d | 20% IF YES, WERE FII IN CERTIFYING CAU YES  JIRY IN ITEM 18 PART 1 OR PAR OWN COUNTY  19  120. D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | NDINGS USED USES OF DEATH' NO (172)  T 2)  T 3)  T 4)  T 4)  T 4)  T 5)  T 6)    |
| 99         |                       | gove rise to immediate cause (a), stoting the underlying couse lost.  PART 2 OTHER SIGNIFICANT  19a DATE OF OPERATION  21a. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING ] CAUSE OF DE (IF EITHER, NOTIFY MEDICAL EXAMINE 21d. IN JURY OCCURRED  WHILE NOT WHILE AT WORK  22a.1 certify that (I) (this hosp sow the deceased olive or above, (I) (we) (did) (did not 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ONDITIONS CONTRIBUTIONS CONTRI | CONSEQUENCE OF WHICH OPER.  RY ONTH DAY Y  URY TORY, OFFICE, FARM, ETC.                         | EAR 19 211. LOCATION STREET  , ond that in (my) (our) opinion DEGREE ATTENDING PHYSICIAN 22e. ADDRESS | 206 AUTOPSY?  YES NO RED (ENTER NATURE OF INJUITED OF ITO A DIRECTOR PHYSIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 20b. IF YES, WERE FIN IN CERTIFYING CAU YES  DWN COUNTY  . 19 ofe and hour and from 22t. D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | NDINGS USED USES OF DEATH' NO [] 17 2)  Y STAI , that (I) (we a the causes state |
| 99         | MEDICAL               | gove rise to immediate cause (o), stoting the underlying cause lost.  PART 2 OTHER SIGNIFICANT  19a DATE OF OPERATION  21a. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING ] CAUSE OF DE (IF EITHER, NOTIFY MEDICAL EXAMINE ]  21d. INJURY OCCURRED  WHILE NOT WHILE AT WORK  22a.1 certify that (I) (this hosp saw the deceased olive or above. (I) (we) (did) (did not 22b. SIGNATURE)  22d. PHYSICIAN'S NAME (1994)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | DUE TO, OR AS A (C)  CONDITIONS CONTRIBUTION FOR THE CONTRIBUTION FOR TH | CONSEQUENCE OF WHICH OPER.  RY ONTH DAY Y  URY ORY, OFFICE, FARM, ETC.  20sed from              | EAR 19 211. LOCATION STREET  210. ATTENDING PHYSICIAN 220. ADDRESS  55 JACKSON                        | 206 AUTOPSY?  YES NO RED (ENTER NATURE OF INJUITED OF ITO AUTOPS TO AUTOPS T | 20% IF YES, WERE FII IN CERTIFYING CAU YES  JIRY IN ITEM 18 PART 1 OR PAR OWN COUNTY  19  120. D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | NDINGS USED USES OF DEATH' NO 172)  Y STAI  , that (I) (we is the causes state   |
| 99         | MEDICAL MEDICAL       | gove rise to immediate cause (a), stoting the underlying couse lost.  PART 2 OTHER SIGNIFICANT  19a DATE OF OPERATION  21a. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING ] CAUSE OF DE (IF EITHER, NOTIFY MEDICAL EXAMINE 21d. IN JURY OCCURRED  WHILE NOT WHILE AT WORK  22a.1 certify that (I) (this hosp sow the deceased olive or above, (I) (we) (did) (did not 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | DUE TO, OR AS A (C)  CONDITIONS CONTRIBUTION FOR THE CONTRIBUTION FOR TH | CONSEQUENCE OF CONSEQUENCE OF WHICH OPER.  RY ONTH DAY Y  URY IORY, OFFICE, FARM, ETC. 23c NAME | EAR 19 211. LOCATION STREET  , ond that in (my) (our) opinion DEGREE ATTENDING PHYSICIAN 22e. ADDRESS | 206 AUTOPSY?  YES NO RED (ENTER NATURE OF INJUDENT OF TO DIRECTION PHYSIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 20b IF YES, WERE FIND CERTIFYING CAU YES  DIRY IN ITEM 18 PART 1 OR PART DWN COUNT  19 ote and hour and from 22t. D  FF CIAN   ONTING MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | NDINGS USED USES OF DEATH NO 172)  T 3)  T 4, that (I) (we a the causes state    |

AND DESCRIPTION OF PERSONS AND ADDRESS OF THE PERSON OF TH 12/04/1985 STON 191 AND AND A 03/3X/1909 76 9 WILLIAM YEARTILL .d. I. I. bully in related and species appropriate and the little and the latest a egge .J messagement till x = 12 message versage borderad 213-11-7360 rm. prierter again tone of the brillian manager with British Larrett Manager and All Larrett Best House of the street Landon Local Co. 1215 St. 1825 S

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1        | FOR<br>STATE                   |                                      |                                         | DEPARTMENT OF                 |           |                    |                 | 5                       | 2            | 0 0           | Ent.    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|--------------------------------|--------------------------------------|-----------------------------------------|-------------------------------|-----------|--------------------|-----------------|-------------------------|--------------|---------------|---------|
| 351073                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |          | REGISTRAR                      |                                      | MI                                      | EDICAL EXAMI                  |           |                    |                 | REG. NO                 |              |               |         |
| 033.010                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |          | ECEASED NAME<br>(THE CA PROHE) | nesr                                 |                                         | WIDDLE                        |           | LAST               |                 | OF ESTI-                | MONTH        | DAY YEAR      | 2b. HOU |
| <b>高级电影</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | de_      |                                | James                                | I I                                     | Fitch                         |           | Imes               | DE              | ATH MATED               | 12           | 9 1985        | 0900    |
| SECTION SECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 3.5      | EX                             | 4. RACE                              | 5 DATE OF BIRTH                         | 6. AGE (IN)                   |           | DER 1 YR. IF UNDER |                 | DATE<br>HOUNCED         | MONIH        | DAY YEAR      | 2d HO   |
| SA SEE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1        | Male                           | White                                | 3 24                                    | 1908 77                       | YRS.      | DATS               |                 | DEAD                    | 12           | 9 1985        | 1045    |
| A E S E S E S E S E S E S E S E S E S E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1/10     | BIRTHPLACE DE                  | ATE OR                               | 76. CITIZEN OF V                        | VHAT COUNTRY?                 | 8. MARRI  | ED NEVER MARRI     | ED 30 9. BA     | LTIMORE CITY O          | R COUNT      |               |         |
| 商品できま                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2        | PA                             | 1                                    | US                                      | SA                            | WIDOW     |                    | 0               | Allogan                 | V/           |               | A.      |
| SEX#R                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1/10     | CITY OR TOWN                   | OF DEATH                             |                                         | OSPITAL, NURSING HOA          |           | ER INSTITUTION     | 120 USUAL O     | CCUPATION (TYPE         | OF WORK      | 126 KIND OF B |         |
| A DA SER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 01:      | linteto                        | no                                   |                                         | Box 19 Flin                   |           | e                  | Maint           | enance                  | Cc           | ountry        |         |
| 5 23997                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | / US     | STATE                          | RSING HOME                           | OR OTHER INSTITUTION.                   | GIVE RESIDENCE BEFORE ADMIS   | SION)     |                    | 13e STREET A    | ·                       |              |               |         |
| A FEER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 201      | ary land                       |                                      | egany                                   | Flintston                     |           | YES NO X           |                 | Box 1                   | 9 /          | 21530         | 1000    |
| 9 Frank                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 116      | FATHER'S NAME                  | A                                    | WIDDLE                                  |                               | 10        | 15. MOTHER'S MAIDE |                 |                         |              |               |         |
| A 384                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 110      | Albert                         |                                      | MIDDLE                                  | Imes                          | 320       | Sadie              |                 | MIDDLE                  | Some         | ervill        | 0       |
| N MANA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Iba      | WAS DECEASE                    | DEVER IN U.S. AR                     | RMED FORCES?                            | 16b. SOCIAL SECUR             | TY NO.    | 17. INFORMANT      |                 | ADDRESS                 | ООЩС         | Z V L L       | 6       |
| MA HA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 11       | (YES, NO, OR UNKNO             | (IF YES, GIVI                        | E WAR OR DATES)                         | 213-12-9                      | 142       | Leah Swi           | ick -           | Kevser.                 | W.           | VA.           |         |
| SE S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | /        | 18 CAUSE O                     | F DEATH (Enter or                    | nly one couse per lir                   | ne far (a), (b), and (c).)    |           |                    |                 | 110 ) 501 ,             |              | APPROXIMA     |         |
| THE STATE OF THE S |          | PARTIDE                        | ATH WAS CAUSE                        | D BY.                                   |                               | monar     | v arrect           |                 |                         |              | Sudd          |         |
| A TRANS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |          | 1000                           | MMEDIA                               | DUE TO, C                               | Cardio-pul                    | OF        | y_arrest           |                 |                         |              | Sudu          |         |
| PRESENTED THE PRESENT OF THE PRESENT |          |                                | ns, if ony, which<br>se to immediate | (6)                                     | Acuto conc                    | noctiv    | o hoart fa         | ilum            |                         |              | minu          | tos     |
| W. WENCEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |          | couse (o)                      | stating the under                    | DUE TO, O                               | Acute cong                    | OF        | e near L la        | Liuie           |                         |              | I             | CCS     |
| DO WENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |          | lying cau                      | ise last.                            | (c)                                     |                               |           | c heart di         |                 |                         |              | vears         |         |
| ANN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |          | PART 2 OTNER SI                | GNIFICANT CONDITIONS                 | CONTRIBUTING TO GEAT                    | N BUT NOT RELATED TO THE TER  |           |                    |                 |                         |              | Tyeurs        |         |
| ECOR<br>BE ENDIN<br>MEDICA<br>AS A LTH<br>CREW                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Z O      |                                |                                      |                                         |                               |           |                    |                 |                         |              |               |         |
| * 70 04                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | MICATION | 19s DATE OF                    | OPERATION                            | 196 CONE                                | DITION FOR WHICH OPE          | RATION W  | AS PERFORMED?      |                 |                         |              | 20 AUTOPSY    | Y?      |
| <b>■ 美麗玉芸芸</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ×Iš      | 3151                           |                                      |                                         |                               |           |                    |                 |                         |              | YES 🗆         | NOXX    |
| SION OF VI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |          |                                | AL CAUSE WAS                         | 21b. TIME O                             | OF INJURY<br>M. MONTH DAY YEA | 21c. HC   | W INJURY OCCURRE   | D (ENTER NATURE | OF INJURY IN ITEM 18 P. | ART I OR PAR |               | -/47    |
| PECATI<br>PECATI<br>POULD<br>VETIVE<br>CORTO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1        | CONTRIBUTI                     | OR<br>NG CAUSE OF                    |                                         |                               | AK        |                    |                 |                         |              |               |         |
| MAN DE STATE OF STATE | MEDICAL  | 21d INJURY C                   | OCCURRED                             |                                         | OF INJURY (AT HOME,           |           | CATION             |                 |                         |              |               |         |
| ARBON  | 3        | AT WORK                        | NOT WHILE (                          | 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 | CTORT, FARM, ETC.)            | ,         | INCEI              | CITY            | OR TOWN                 | COU          | NTY           | STATE   |
| E PY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |          |                                |                                      | as of the remains d                     | escribed above, held an       | Autaps    | y , Inspection     | V               | uiry X and              | 11           |               |         |
| A PA DE A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 36       | deoth resulte                  |                                      | ge of the remains                       |                               | vicide .  | Hamicide .         | Undetermin      |                         | l in my opi  | nion          |         |
| EXAM<br>CERTIF<br>JUD BE<br>WITH<br>AARYL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |          | Qeom resum                     | la man                               | 7                                       | Accident, 3                   | olcide [] | TITLE (SPECIFY)    | Onderermin      | a monner,               |              |               |         |
| S S S S S S S S S S S S S S S S S S S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1        | ACTUAL<br>SIGNATURE            | H                                    | //                                      |                               | М.        | D 1                | MEDICAL I       | VAMILIED                | DATE         | 12-           | 9-85    |
| MEDICAL E<br>ECUTE THE<br>CE 4 SHOU<br>FUNERAL<br>TER DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 7        |                                | 1/1/2                                | 1 //w                                   |                               |           | o                  | MEDICAL I       | MAMINEK                 | SIGNEL       |               | 2 00    |
| A STATE OF S | 1        | EXAMINER'S<br>(TYPE OR PRI     | NAME DO                              | ul drow                                 | M_D                           |           | ADDRESS Memor      | ial Hos         | nital. C                | umba         | rland         |         |
| DAG DAG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 23a      |                                | TION, REMOVAL                        | ul Show,                                | 23c. NAME OF CI               |           | R CREMATORY INT    | 23d LOCATI      | ON                      | SAULE -      | HAHV          |         |
| 07/84 BP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |          | Bur                            | ial                                  | 12/12/8                                 |                               |           | emetery            | Chan            | ysvill                  | e. B         | edfor         | d.PA    |
| 25M<br>DHMH - 17                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 24       | FUNERAL DIREC                  | TOR                                  | ADDRE                                   |                               |           |                    |                 | STRAR 256 REGIS         | TRAR'S S     | GNATURE       |         |
| (VR A15 ME (5)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | )        | John                           | J. Hafe                              | er, Jr.                                 |                               | MD        | U                  | EU 13           | 1985 700                | ויוסטוין     | assar shows   | بعالات  |

STATE OF MARYLAND

OSENS VALUE EN X ATT THE MARKET TEND - MOTERN SINCE TA Entel 12/12/85 Nt. 21on Cenetary Chemeysville, Sectord, En 

FOR STATE CERTIFICATE OF DEATH REGISTRAR

SILCOX MERRITT FUNERAL SERVICE CUMBERLAND, MARVIN 1

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

154 DATE REC'D. BY REGISTRAR 23b. REGISTRAR'S SIGNATURE

| REG. N | 10.   |     |      |      |
|--------|-------|-----|------|------|
| DEATH  | MONTH | DAY | YEAR | 2b H |
|        |       |     |      |      |

|   |               | EASED NAME                                                                             | FIRST                                               |                                | MIDDLE                               | ŧ                     | AST                                       | 20 DATE O  | FDEATH MONTH                      | DAY                                  | YEAR            | 2b HOU                   | 8:15  |
|---|---------------|----------------------------------------------------------------------------------------|-----------------------------------------------------|--------------------------------|--------------------------------------|-----------------------|-------------------------------------------|------------|-----------------------------------|--------------------------------------|-----------------|--------------------------|-------|
|   | (11PE         | OR PRINT!                                                                              | ERMA                                                | M                              | AXINE                                | J                     | OHNSON                                    | Dece       | mber 5,                           | 1985                                 | - 30            | P                        | . W   |
|   | 3. SEX        | (                                                                                      |                                                     | 4 RACE                         |                                      | 5. DATE C             |                                           | 6. AGE (IN | YEARS LAST BIRTHDAY)              | IF UNDER                             |                 | IF UNDER                 |       |
|   |               | FEMALE                                                                                 |                                                     | WHITE                          |                                      | FEB™                  | 1 1 PAY 1926 AR                           | 59         | Y                                 | 'RS.                                 | DAYS            | HOURS                    | MIN.  |
|   | 7a BIF        | RTHPLACE (STATE                                                                        | OR FOREIGN                                          | 76 CITIZEN OF                  | WHAT COUNT                           | RY? 8.                | NEVER MARRIED                             | 9. BALTIMO | ORE CITY OR CO                    | JNTY OF DE                           | ATH             |                          |       |
| 2 |               | MARYLAN                                                                                |                                                     | USA                            |                                      | WIDOWE                | D DIVORCED                                |            | Alle                              | gany                                 |                 |                          | MD.   |
|   | 10 CI         | TY OR TOWN OF E                                                                        | DEATH                                               |                                | HOSPITAL, NUI<br>H FACILITY, GIVE ST |                       | OR OTHER INSTITUTION                      |            | OCCUPATION<br>RK FOR MOST OF WORK |                                      | KIND O<br>USTRY | F BUSINE                 | SSOR  |
| 4 | C             | umberlan                                                                               | d                                                   |                                |                                      | Hospita               | a1                                        | RECPT      |                                   |                                      |                 |                          |       |
| 6 | USUA<br>13g S | AL RESIDENCE (IF N<br>TATE<br>RYLAND                                                   |                                                     | OTHER INSTITUTION              |                                      | FORE ADMISSION        | 134 INSIDE CITY LIMITS?                   |            | ADDRESS / ZIP                     | CODE O                               | 215             | Dá                       | 2     |
|   | 14 FA         | THER'S NAME WILLIAM                                                                    | R. E                                                | S. S                           | MITH LAST                            |                       | HILDA                                     | ME         | R. VALI                           | ENTINE                               | LAST            |                          |       |
|   |               | AS DECEASED EV                                                                         |                                                     | MED FORCES?<br>E WAR OR DATES) | 166. SOCIAL S<br>216-22              | ECURITY NO.<br>2-6430 | IRVIN JOHNSON                             | N 1100     | ADDRESS<br>BEDFORD                | ST CU                                | MBER            | LAND                     | ) MD. |
|   |               | Conditions, if o gove rise to couse (a), ste underlying co                             | I WAS CAUSE IMMEDIAT  my, which immediate ating the | DUE TO, O                      | R AS A CONSE                         | OUENCE DE<br>Retre    | anest dessor                              | rito       | ,                                 | <i>A</i>                             | ci (i           | MATE INTER<br>DINSET AND | - Li  |
|   | CERTIFICATION | PART 2. OTHER S                                                                        | IGNIFICANT C                                        | scup                           |                                      |                       | NOT RELATED TO THE TERM                   |            |                                   |                                      |                 |                          |       |
|   | TIFICA        | 190 DATE OF OPE                                                                        | KAHON                                               | TYB COND                       | IION FOR WH                          | IICH OPERATIO         | N WAS PERFORMED                           | 200 AUT    | NO IN C                           | IF YES, WERE<br>ERTIFYING C<br>YES [ |                 |                          | TH?   |
|   | MEDICAL CER   | 21g. ACCIDENT WAS OR CONTRIBUTING LIFEITHER NOTIFY M 21d. INJURY OCCI WHILE AT WORK AT | CAUSE OF DEA                                        | P. 21e PLACE                   | M, MONTH                             | 19<br>ICE FARM ETC 1  | 216 HOW INJURY OCCURE 211 LOCATION STREET |            | CITY OR TOWN                      | COL                                  | YINL            | S                        | TATE  |
|   |               | 22a I certify that<br>saw the dece<br>abave (1) (we<br>22b. SIGNATURE                  | -                                                   | tal) attended th               |                                      | 9 85, or              | nd that in (our) opinion of DEGREE        |            | ed on the dote one                | d hour and In                        | om the o        | hold (v<br>ouses sta     |       |
|   |               | (                                                                                      | 18/2                                                | Un                             |                                      | 7                     |                                           |            | STAFF PHYSICIAN                   |                                      | 40              | e FS                     |       |
|   |               | 22d PHYSICIAN'S                                                                        |                                                     |                                |                                      |                       | 22e ADDRESS 955 FT                        |            |                                   |                                      |                 |                          |       |
|   |               | Dr.                                                                                    | A. Bol:                                             | Lino                           |                                      |                       | Cumber                                    | rland,     | MD 2150                           | 2                                    |                 |                          |       |
|   | 230 B         | URIAL, CREMATIO                                                                        | N, REMOVAL                                          | 23b DATE                       | 12                                   | 3c. NAME OF C         | EMETERY OR CREMATORY                      | 23d LOC    | ATION                             |                                      |                 |                          |       |
|   | (5            | SPECIFY)  RTID T AT                                                                    |                                                     | DEC 8 1                        | 985                                  | SINSET I              | MEMORIAI. PARK                            | CIMB       | FRI AND A                         | LIEGAN                               | Y MA            | RYLA                     | ND    |

DHMH - 16 60M 7/84

TO FUNERAL DIRECTOR. should be detached for with the State Dept of IMPORTANT: If Ite

(VRA 15, 4)

24 FUNERAL DIRECTOR

## STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| ~ | - | de lan | (3 | 63 |
|---|---|--------|----|----|
|   |   |        |    |    |
|   |   |        |    |    |

| 1 | REGISTRA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | AR                                                          |                          |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CERTIF          | ICATE OF DEATH                                | REG.                                                                          | NO.                       |                 |                                           |     |  |
|---|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------|---------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------------------------------------|-------------------------------------------------------------------------------|---------------------------|-----------------|-------------------------------------------|-----|--|
| ı | 1 DECEASED NA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | AME                                                         | FIRST                    | WIDDIE                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ı               | LAST                                          | 20 DATE OF DEATH                                                              |                           | DAY YEAR        | DAY YEAR 2b. HOUR                         |     |  |
|   | (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ROBERT                                                      |                          | LYNN KARLOW               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 | A                                             | December                                                                      | 30,                       | 1985            | 1985 10:00                                |     |  |
| 1 | 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                             |                          |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | S. DATE C       |                                               | IF UNDER 1 YEAR                                                               | R IF UNDER 24 HRS         | 5               |                                           |     |  |
| 1 | MALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                             | 20.10                    | WHIT                      | E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | JUNE            |                                               | 33                                                                            | v                         | RS DAYS         | HOURS MIN                                 | Ja  |  |
| 1 | To BIRTHPLACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (STATE OR FOR                                               | EIGN I                   | TE CITIZEN OF             | WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 8.              |                                               | 9. BALTIMORE CITY                                                             |                           |                 |                                           | _   |  |
| 2 | MARY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | LAND                                                        |                          | USA                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | WIDOWE          | D LI NEVER MARRIED X                          | Allegany                                                                      |                           |                 | A                                         | AD. |  |
| A | 10 CITY OR TOV                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                             | 1                        | 11. NAME OF H             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | NG HOME C       | OR OTHER INSTITUTION                          | 120 USUAL OCCUPA                                                              |                           |                 | OF BUSINESS O                             |     |  |
| 1 | Cumber                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Land                                                        |                          | Memori                    | al Hospi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | tal             |                                               | BURTONS M                                                                     |                           |                 |                                           |     |  |
| 1 | USUAL RESIDEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                             | HOME OR                  |                           | GIVE RESIDENCE BEFOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                 | 1124 INICIDE CITY I JUITES                    | 13e STREET ADDRESS                                                            |                           |                 |                                           | _   |  |
| 7 | MARYLA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                             | ALLE                     |                           | CUMBERT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                 | 13d. INSIDE CITY LIMITS?                      | 218 SCHLEY                                                                    |                           |                 | 2150                                      | 2   |  |
| 1 | 14 FATHER'S NA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                             |                          | AIDDLE                    | LAST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                 | 15. MOTHER'S MAIDEN NA                        | AME                                                                           | DIL                       |                 |                                           | _   |  |
| 4 | ROBER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                             | HEN                      |                           | KARLOWA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                 | MARY                                          | MIDDLE                                                                        |                           | BURT            | ON ST                                     |     |  |
| 1 | 160 WAS DECEA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | WAS DECEASED EVER IN U.S. AR                                |                          | AED FORCES?               | MED FORCES? 166 SOCIAL SECURITY NO. 17 INFOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                 | 17 INFORMANT                                  | ADD                                                                           | RESS                      | DOILTOIL        |                                           |     |  |
| 1 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (YES, NO OR UNKNOWN) [IF YES GIVE                           |                          | 213-64-9136 ROBERT H. KAR |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |                                               | LOWA 218 SCHLEY STREET CUMBERLA                                               |                           |                 |                                           |     |  |
| 1 | 18 CAUSI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | OF DEATH                                                    | Enter onl                | y one couse per           | line for (a), (b), or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | nd (c)          |                                               |                                                                               |                           |                 | XIMATE INTERVAL                           | -   |  |
| 1 | PART                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | . DEATH WAS                                                 |                          | BY:<br>E CAUSE (a)        | Stal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | LAS             | soily                                         | places                                                                        | Care                      |                 |                                           |     |  |
|   | 10 15 50                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | DUE TO OR AS A CONSEQUENCE OF.                              |                          |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |                                               |                                                                               |                           |                 | 20010                                     |     |  |
| I | Condition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Conditions, if ony, which                                   |                          |                           | ACTUAL CONTRACTOR OF THE PROPERTY OF THE PROPE | cil             | A-V                                           | male                                                                          | 0=1                       | nate            |                                           |     |  |
| ı |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | se to immed                                                 |                          | DUE TO OF                 | DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                 |                                               |                                                                               |                           |                 |                                           |     |  |
| 1 | underlyir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ng couse                                                    | last                     | 101_                      | Draw                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | tea.            | crawo                                         | 150                                                                           | 400                       | u               |                                           |     |  |
| 1 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | THER SIGNIF                                                 | ICANTO                   | ONDITIONS CC              | ONTRIBUTING TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | DEATH BUT       | NOT RELATED TO THE TERM                       | MINAL DISEASE OR CO                                                           | NDITION                   | GIVEN IN PART   | la                                        | =   |  |
|   | ō N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                             |                          |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |                                               |                                                                               |                           |                 |                                           |     |  |
| 7 | CERTIFICATION 13 TO STATE (ATTION 12 TO STATE | 190 DATE OF OPERATION                                       |                          |                           | TION FOR WHICH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | OPERATIO        | N WAS PERFORMED                               | 20a AUTOPSY?                                                                  | 20b. I                    | FYES, WERE FIND | VERE FINDINGS USED<br>NG CAUSES OF DEATH? |     |  |
| - | TIE .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                             |                          |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |                                               | YES NO                                                                        |                           | YES             | NO 🗌                                      | 2   |  |
|   | 00.00112011                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH |                          |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                           |                 |                                           |     |  |
|   | (IF EITHER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (IF EITHER NOTIFY MEDICAL EXAMINER)                         |                          | · III                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |                                               |                                                                               |                           |                 |                                           |     |  |
| 1 | #                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                             |                          |                           | 21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE FARM ETC.)  21f LOCATION STREET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                 |                                               |                                                                               | CITY OR TOWN COUNTY STATE |                 |                                           |     |  |
| 1 | AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | NOT WHILE                                                   |                          |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |                                               |                                                                               |                           |                 | /                                         |     |  |
| ١ |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                             |                          |                           | e deceased from_                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 2/3             | 124 1943, to 12/30, 19 52, that (f) (we) last |                                                                               |                           |                 |                                           |     |  |
|   | apave                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                             | alive on _<br>) (did nat | yew the bady              | ofter death.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <u>, 1</u> , ar | nd that in (my) (our) opinian                 | deoth accurred an the dote and have and from the causes stated                |                           |                 |                                           |     |  |
|   | 22b. SIGN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ATURE                                                       | 1/1                      | 45/100                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |                                               |                                                                               |                           |                 | E SIGNED                                  |     |  |
|   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4                                                           |                          | CC                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |                                               | MEDICAL ST<br>DIRECTOR PHYS                                                   |                           |                 | 100                                       |     |  |
| Н |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ICIAN'S NAM                                                 |                          |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 | 27e ADDRESS 441 N. Centre Street              |                                                                               |                           |                 |                                           |     |  |
|   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Willia                                                      |                          |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 | Cu                                            | umberland,                                                                    | MD 2                      | 1502            |                                           |     |  |
|   | 23a BURIAL, CRE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | EMATION, RE                                                 | MOVAL                    | 23b DATE                  | 23€                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | NAME OF C       | EMETERY OR CREMATORY                          | 23d LOCATION                                                                  |                           | COUNTY          | STATE                                     |     |  |
|   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | TIR TAT.                                                    |                          | I TAN 2                   | 1986 RT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | MTCHA           | FIS CEMETERY                                  |                                                                               | C AT                      | I ECANV MA      |                                           |     |  |

DHMH - 16 60M 7/84

BP.

TO FUNERAL DIRECTOR. After this certificate has been signed by should be detached for use as the burial-transit permit. Then please with the State Dept. of Health and Mental Hygiene prior to burial, cr. IMPORTANT: If them 21 is marked or Item 18 shows ony injury. are ath

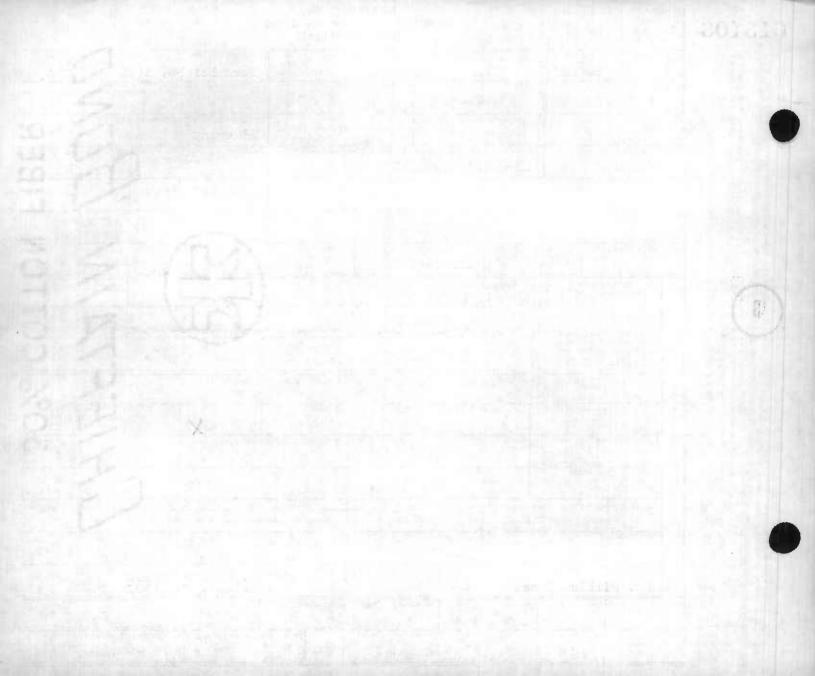
(VRA 15, 4)

24 FUNERAL DIRECTOR SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARVIANT

250 PATI REED BY REGISTRAR 250 REGISTRAR'S SIGNATURE

250 PATI REED BY REGISTRAR 250 REGISTRAR'S SIGNATURE

GUILL DEVILOR - Florida CO.



| 353209                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |          | REGISTRAR                                                               |                                       |                                   |                            | CERTIF                             | ICATE OF DEATH                       |                                                              | REG. NO.           |                                             | 1       |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-------------------------------------------------------------------------|---------------------------------------|-----------------------------------|----------------------------|------------------------------------|--------------------------------------|--------------------------------------------------------------|--------------------|---------------------------------------------|---------|--|
| 0.6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |          | CEASED NAME<br>OR PRINT)                                                | FIRST                                 | MIDI                              | DLE                        |                                    | AST                                  | 2a. DATE OF                                                  | DEATH MON          | TH DAY YEAR                                 | 26 HOUR |  |
| 1 000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |          |                                                                         | Agnes                                 | Loui                              | se                         | Kidd                               |                                      |                                                              | ber 7,             |                                             | 8:30p   |  |
| 2 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 3.58     | X                                                                       |                                       | 4. RACE                           |                            | 5. DATE (                          |                                      |                                                              | ARS LAST BIRTHDAY  | MONTHS DA                                   |         |  |
| 4000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 11.2     | male                                                                    |                                       | White 47                          |                            | 25 1923                            | 62                                   |                                                              | YRS.               |                                             |         |  |
| 6 62 51                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |          | RTHPLACE (STATE                                                         |                                       |                                   | IAT COUNTRY                | COUNTRY? 8 MARRIED   NEVER MARRIED |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH                         |                    |                                             |         |  |
| 1 100                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | We       | sternpor                                                                |                                       | USA                               |                            | WIDOW                              | DIVORCED                             |                                                              |                    |                                             |         |  |
| by the f                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Çu       | mberland                                                                |                                       |                                   |                            |                                    |                                      | The USUAL OCCUPATION THE TRANSPORT OF WORKING LIFE) HOSPITAL |                    |                                             |         |  |
| 35                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 13a. 3   | at RESIDENCE (#1<br>STATE<br>aryland                                    | NURSING HOME OR GATT                  |                                   |                            |                                    | 13d. INSIDE CITY LIMITS?<br>YES NO [ | 703 Mitchell Drive 21550                                     |                    |                                             |         |  |
| ///                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | C        | FATHER'S NAME  Charles S Dayton  15. MOTHER'S MAIDEN NAME  Etheli Green |                                       |                                   |                            |                                    |                                      | reen                                                         | LAST               |                                             |         |  |
| (B) 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |          | VAS DECEASED EV                                                         |                                       | MED FORCES? 16                    | \$ SOCIAL SEC<br>2191458   |                                    | Mrs. Glenda                          | Newcom                                                       | b Oakl             |                                             | 21550   |  |
| agains that the displayed by the or the place employed to be for the place or other transfer | NOI      | Canditians, if a gove rise to cause (a), st underlying co               | immediate<br>tating the<br>ause last. | (c)                               | S A CONSEOU                |                                    | NOT RELATED TO THE TER               | MINAL DISEASE                                                |                    |                                             | T Ita   |  |
| on<br>her break                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | FICAT    | 19a. DATE OF OPE                                                        | ERATION                               | 196 CONDITIO                      | ON FOR WHICE               | OPERATIO                           | N WAS PERFORMED                      | 200 AUTO                                                     |                    | LIF YES, WERE FIN<br>CERTIFYING CAUS<br>YES |         |  |
| SICIAN: 1<br>g physic<br>certificate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | CAL CERT | 21a, ACCIDENT WAS<br>OR CONTRIBUTING<br>(IF EITHER, NOTIFY)             | CAUSE OF DEA                          | HOUR A.M.                         | MONTH E                    | AY YEAR                            | 21c. HOW INJURY OCCU                 | RRED (ENTERNAL                                               | URE OF INJURY IN I | TEM 18 PART I OR PART                       | 2)      |  |
| NG PHY<br>offer this                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | MEDICAL  | 21d. INJURY OCC                                                         | TWHILE WORK                           | 21e. PLACE OF<br>LAT HOME, STREET | INJURY<br>FACTORY, OFFICE. | FARM, ETC.)                        | 211 LOCATION<br>STREET               |                                                              | CITY OR TOWN       | COUNTY                                      | STATE   |  |
| ATTEND<br>sspital or<br>ECTOR: A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |          | sow the dec                                                             | eased alive an                        | tal) attended the d               | 19                         | 8 <u> -</u> , a                    | nd that in (my) (aur) opinio         | death occurred                                               | an the date a      | nd haur and fram                            |         |  |
| ITAL OR<br>by the hy<br>RAL DIRE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |          | 775 SIGNATURE                                                           | Y                                     | Nel                               | Виц                        | 9                                  |                                      | MEDICAL<br>MEDICAL<br>MEDICAL                                | STAFF<br>PHYSICIAN |                                             | 2-8-6   |  |
| Hold Spiral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |          | John N                                                                  | Mehanna                               |                                   |                            |                                    | 909-B Seto                           | n Drive                                                      | Cumbe              | rland, M                                    | 21502   |  |
| BP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |          | BURIAL, CREMATIC<br>ISPECIEY) Buri                                      | ON, REMOVAL                           | 236. DATE<br>10-11-8              | 23c.<br>F                  | NAME OF C                          | emetery or crematory<br>Cemetery     | 123d LOCA                                                    | TION               | t Allegan                                   |         |  |
| DHMH - 16 50M 4/83<br>(VRA 15, 4)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |          | uneral direction                                                        | ral Ser                               | vice Wes                          | ternpor                    | t, Md                              | 21562 DEC                            | ATE REC'D. BY RE                                             |                    | REGISTRAR'S SIGN                            |         |  |

STATE OF MARYLAND

Boal Funeral Home

|                                  |                     | 2005. PD 21562 PM |                           |
|----------------------------------|---------------------|-------------------|---------------------------|
| December 7, 1985 8:30            | Months Months       | netwo! ne         | TOTAL STATE OF THE PARTY. |
|                                  | C. Pe Es 41         | 9                 | 97.00                     |
| Allegany County.                 | x                   |                   | Jzourne, en               |
| Levinos commos .ne               |                     | dries/I feme?     | bearing fire              |
| 702 Headl May 150                | x                   | tto E             | mile handyest             |
|                                  |                     | nė iš ja          | E mein                    |
| Darks . Mil. Boschill descript   | Senfi . Serv. Dorse | ESTOTO TWO        | 20                        |
|                                  |                     |                   |                           |
|                                  |                     |                   |                           |
|                                  |                     |                   |                           |
| on Indian, Outberland, 1th 21802 |                     |                   |                           |
| westermont all was 22.           | hillos Desetur      |                   | Esterda                   |
| Total stranger of 18 3 4         | t, skis a ,t        | postupine solve   | incom . ofoc              |

FOR STATE

## STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

|  | PEG | NO |
|--|-----|----|

| REGISTRAR                                                                             |                                                                                                                                                                  |                       |                      | CERTII      | ICATE OF DEATH                |               | REG. NO.            |             |                       |                    |  |
|---------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|----------------------|-------------|-------------------------------|---------------|---------------------|-------------|-----------------------|--------------------|--|
| DECEASED NAME                                                                         | FIRST                                                                                                                                                            | ,                     | MIDDLE               |             | LAST                          | 20. DATE O    | F DEATH MONTH       | DAY         | YEAR                  | 2h HOUR            |  |
| (TIPE OR PRINT)                                                                       | IRMA                                                                                                                                                             | N                     | í.                   | KLI         | NE                            |               | Dec.                | 29,         | 1985                  | 11:20 M            |  |
| 3 SEX                                                                                 |                                                                                                                                                                  | 4 RACE                |                      | 5. DATE C   |                               | 6 AGE (IN     | YEARS LAST BIRTHDAY |             | DER I YEAR            | IF UNDER 24 HRS    |  |
| femal                                                                                 | е                                                                                                                                                                | whit                  | e                    | MONTH       | 3-28-1916 YEAR                |               | 69 <sub>v</sub>     | (RS         | DAYS                  | HOURS MIN.         |  |
| BIRTHPLACE (STATE                                                                     | TE OR FOREIGN                                                                                                                                                    | 76 CITIZEN OF         | WHAT COUNTRY         | ? 8         | D NEVER MARRIED               | 9 BALTIMO     | ORE CITY OR COL     |             | EATH                  |                    |  |
| MD                                                                                    |                                                                                                                                                                  | USA                   |                      | WIDOWE      |                               |               | Allegany            |             |                       | MD.                |  |
| CITY OR TOWN OF                                                                       | FDEATH                                                                                                                                                           |                       | HOSPITAL, NURSI      |             | OR OTHER INSTITUTION          |               | OCCUPATION          | INCLUSED IN | L KIND OF             | F BUSINESS OR      |  |
| Cumberlan                                                                             | d                                                                                                                                                                | Me                    | emorial I            | lospit      | al al                         | forme         | r employ            | ee          | text                  | tile               |  |
| JSUAL RESIDENCE (IF<br>130. STATE<br>MD                                               | 13b COU                                                                                                                                                          |                       | GIVE RESIDENCE BEFO  | WN .        | 13d INSIDE CITY LIMITS?       | 13e STREET    | ADDRESS / ZIP (     | CODE        | ie /21                | 502                |  |
| 4 FATHER'S NAME                                                                       |                                                                                                                                                                  |                       | Odinoci.             | 10110       | 15. MOTHER'S MAIDEN NA        |               | - GIGIIG            | AVCITO      | C/ 21.                | 202                |  |
| Mat                                                                                   | thew Ar                                                                                                                                                          | drews                 | LAST                 |             | PIRST Dai                     | sy May        | George              |             | LAST                  |                    |  |
| 60 WAS DECEASED E                                                                     |                                                                                                                                                                  | MED FORCES?           | 166 SOCIAL SEC       | URITY NO.   | 17 INFORMANT                  |               | ADDRESS             |             |                       |                    |  |
| UO OK ONKNOW                                                                          | N) (IF TES, GI                                                                                                                                                   | YE WAR ON DATES)      | 214-07-              | -6342       | Mr. Maynard                   | O. Kli        | ne, Cumb            | erlan       | id, Mi                | D - hust           |  |
| 18 CAUSE OF E                                                                         | DEATH (Enter or                                                                                                                                                  | nly ane cause per     | line far (a), (b), a | nd (c_)     | 1                             | 1             | ,                   |             | APPROXIA<br>BETWEEN C | MATE INTERVAL      |  |
| PART I. DEA                                                                           | TH WAS CAUSE                                                                                                                                                     | D BY:<br>TE CAUSE (a) |                      | Cere        | bo Vasarla                    | He            | Ciolent             |             |                       |                    |  |
| Canditions, if gave rise to cause (a),                                                | immediate<br>stating the                                                                                                                                         | (b)                   | R AS A CONSEQUE      |             | schol A                       | 1/203         | elesso.             |             |                       |                    |  |
| underlying o                                                                          | underlying cause last. (c)                                                                                                                                       |                       |                      |             |                               |               |                     |             |                       |                    |  |
| PART 2 OTHER                                                                          | SIGNIFICANT                                                                                                                                                      | CONDITIONS CO         | Jacks 1              | DEATH BUT   | NOT RELATED TO THE TERM       | ellul         | EOREONDITION        | DO THE      | PART 110              | Dolet              |  |
| 190 DATE OF OF  210. ACCIDENT WA  OR CONTRIBUTING  (IF EITHER NOTES)  210. IN JURY OC | PERATION                                                                                                                                                         | 19b. COND             | MON FOR WHICH        | H OPERATIO  | N WAS PERFORMED               | 20a AUTO      |                     | F YES, WELL |                       | OF DEATH?          |  |
| 210. ACCIDENT WA                                                                      | AS UNDERLYING                                                                                                                                                    | 216. TIME O           |                      | 19100       | 21c HOW INJURY OCCUR          |               |                     |             | OR PART 2)            |                    |  |
| OR CONTRIBUTING                                                                       |                                                                                                                                                                  |                       | M. MONTH [           | PAY YEAR    |                               |               |                     |             |                       |                    |  |
| 21d INJURY OC                                                                         | 21d INJURY OCCURRED 21e PLACE                                                                                                                                    |                       |                      |             | 21f. LOCATION                 |               | CITY OR TOWN        |             | OUNTY                 | STATE              |  |
| ANTHER IN                                                                             | OT WHILE                                                                                                                                                         | (AT HOME STR          | EET, FACTORY OFFICE, | FARM, ETC ) | ZIMEET                        |               | CITY OR TOWN        |             | CONT                  | STATE              |  |
| 220.1 certify the                                                                     | at (1) (this hasp                                                                                                                                                | ital) attended the    | e deceased fram.     |             | , 19                          | , ta          |                     | . 19        | , t                   | that (I) (we) last |  |
| saw the de                                                                            | ceased alive an                                                                                                                                                  | it) view the hady     | ofter death          | , ai        | nd that in (my) (aur) apinian | death accurre | ed an the date and  | d have and  | from the c            | auses stated       |  |
|                                                                                       | abave. (I) (we) (did) (did not) view the body after death.  22b. SIGNATURE  NARanjillan DEGREE  ATTENDING MEDICAL STAFF PHYSICIAN DIRECTOR PHYSICIAN   12 / 29/8 |                       |                      |             |                               |               |                     |             |                       | 129/85             |  |
| 224. PHYSICIAN                                                                        | STANAL (TYPE C                                                                                                                                                   | OR PRINT)             | 1/                   |             | 22e ADDRESS                   |               |                     | , ,         |                       | 1/0)               |  |
| Dr. R.                                                                                | Barrer                                                                                                                                                           | a / for               | 16                   |             | The Memor                     | ial Ho        | spital M            | edica       | 1 Bui                 | ilding             |  |
| 30 BURIAL, CREMATI                                                                    | ION, REMOVAL                                                                                                                                                     | 23 DATE               | 23c                  | NAME OF C   | EMETERY OR CREMATORY          | 23d LOC/      | ATION               |             |                       |                    |  |
| (SPECIFY) Bur                                                                         | ial                                                                                                                                                              | 1-2-1                 | 1986 F               | Rose H      | ill Cemetery                  |               | mberland            | All         | egany                 | V MD               |  |
| 4 FUNERAL DIRECTO                                                                     |                                                                                                                                                                  |                       |                      |             | 250. DAT                      |               | REGISTRAR 25h. RE   |             |                       |                    |  |
| James F.                                                                              | Scarpe                                                                                                                                                           | lli, Cum              | berland.             | MD 2        | 1502 MAN                      | 2 1           | 36 dite             | Burdon      | ~ Jon                 | delle              |  |

DHMH - 16 60M 7/B4 (VRA 15, 4)

BP.

TO FUNERAL DIRECTOR ... should be detached for use with the State Dept. of Hea

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST.,

250 DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

24 FUNERAL DIRECTOR

Allen Rotruck Keyser, W.Va.

DHMH - 16 60M 7/B4

(VRA 15, 4)

ELORG CLYGE LABIS DECREER 7, 1608 1:50P

White July 2, 192b of

Mary and July 3... Allerany column

Cumberless Sacrep Hear Hospital actions Chissis By.

W.Vo. Mineral Reyser X 533 St. Cloud at. 2.575

Clyde - Lamis - Priescolumn

69 Ser. 12...

10. 10-16-9894 Lens B. Landis 333 St. Gloud By.

MINTERAL MEDICAL MERG. CAMERIAND, NO 21501

milen morrock Keyser, M.Va. utb 12 185 jumisus. Your

And all those is a second of the second of t

| TORCEASED NAME  TORCEASED NAME | 17049                                                 | 1-        | FOR<br>STATE                                                         | m G6    | 12 Item                                          | 5             | 2/25/8              | DEPA                    |                      | NT OF I                   | HEALTH     | AARYLAI<br>I AND M  | ENTAL                   |              |                  |                | J             | 2                               | 3     | .3           | 4           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-----------|----------------------------------------------------------------------|---------|--------------------------------------------------|---------------|---------------------|-------------------------|----------------------|---------------------------|------------|---------------------|-------------------------|--------------|------------------|----------------|---------------|---------------------------------|-------|--------------|-------------|
| S. SEX   4. RACE   S. DAJF OF BIRTH   DAY   YEAR   6. AGE (INYEARS)   FUNDER 1 YR   IF UNDER 24 HRS. 12. DATE   MONTHS   DAYS   MRN.   PRONOUNCED   DATE   MONTHS   DAYS   MRN.   PRONOUNCED   DATE   MONTHS   DAYS   MRN.   PRONOUNCED   DAYS   MRN.   DAYS      | /                                                     | 1. DEC    | EASED NAM                                                            |         | FIRST                                            |               |                     | MIDDLE                  |                      |                           |            | LAST                | CATE                    | OF DEA       | 20. DATE         | KNOWN          | 4 🗆 w         |                                 |       |              | 26 HOUI     |
| Maryland   U.S.A.   MARRIED   NEVER MARRIED   SALTIMORE CITY OR COUNTY OF DEATH   Maryland   U.S.A.   MARRIED   NEVER MARRIED   NEVER MARRIED   Maryland   Maryland   Never markied   Never ma   | N STREET                                              |           |                                                                      | _       |                                                  | Mani          | H DAY               | YEA                     | AR 6.                | AGE (IN YEA               | ARS IF UN  | IDER 1 YR.          |                         |              | 2c. DATE         | NCED           | M             | ÓNIH                            | DAY   | YEAR         |             |
| Westernport  USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMRSSON)  136, STATE Maryland  137, CITY OR TOWN Maryland  138, COUNTY Maryland  138, CITY OR TOWN Maryland  136, INSIDE (ITY LIMITS? YEST)  130, INSIDE (ITY LIMITS? YEST)  131, DSFEET MODRESS  132, DSFEET MODRESS  134, INSIDE (ITY LIMITS? YEST)  134, INSIDE (ITY LIMITS? YEST)  135, MOTHER'S MAIDEN NAME FREST  Marie  146, SOCIAL SECURITY NO. WW2  157, NO, OR INSINON NO. WW2  167, SO, OR INSINON NAME FREST  ADDRESS  WW2  168, SOCIAL SECURITY NO. WW2  178, OR MOTHER'S MAIDEN NAME FREST  Marie  179, INFORMANT  ADDRESS  WW2  188, CAUSE OF DEATH (Enter anly one cause per line for (a), (b), and (c).) Cardiac arrest  Conditions, if ony, which gave rise to immediate couse (a) stating the under- lying couse lost.  (c)  PART 2 DINER SIGNIFICANT CONDITIONS CONTRIBUTION TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 35                                                    | M         | aryland                                                              |         |                                                  | 7ь. СІТІ<br>U | S.A                 | VHAT CO                 |                      | Y?                        | MARR WIDOV | ED 🛣                | DIVOR                   | CED 🗆        | Al               | Legar          | ny            |                                 |       | EATH         | MI          |
| 134 STATE   134 MATTY   134 MATTY   134 STATE   134 MATTY   134 STATE   134    | 100                                                   | We:       | sternpo                                                              | rt      |                                                  | 402           | Mary                | land                    | d STATE              | TADDRESS)                 |            | EK INSTITU          | TION                    | FOR          | MOST OF WOR      | RKING LIFE)    | (TYPE OF      |                                 | OR    | INDUST       | RY          |
| John A. Laughlin  160. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES  18. CAUSE OF DEATH (Enter only one cause per line for (q), (b), and (c).) PART I DEATH WAS CAUSED BY.  Cardiac arrest  IMMEDIATE CAUSE (a)  Coronary artery heart disease  Output To, OR AS A CONSEQUENCE OF  LAST  Marie  Hohing  17. INFORMANT  ADDRESS  Beattie Cumberland, Md.  APPROXIMATE INTERVAL SETWEEN ONSET AND DEATH SUDDET  Output To, OR AS A CONSEQUENCE OF  LOST ON AS A CONSEQUENCE OF  Output To, OR AS A CONS | 36                                                    | Ma:       | ryland                                                               |         |                                                  |               |                     |                         |                      |                           |            | YES                 | NO [                    | 1            |                  | rian           | d Av          | eo                              | 21    | 56           | ,2          |
| Yes WW2 214-14-7881 Mrs. Barbara Beattie Cumberland, Md.  18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), ond (c).) PART I DEATH WAS CAUSED BY: Cardiac arrest IMMEDIATE CAUSE (a)  DUE TO, OR AS A CONSEQUENCE OF  Conditions, if ony, which gave rise to immediate couse (o) stating the underlying couse loss.  PART 2 OTNER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 116                                                   |           | John                                                                 | ) EVED  | A.                                               | Lau           | _                   |                         |                      |                           | (1)0       | M                   | arie                    | DEN NAME     | ٨                |                |               | lohi                            |       | AST          |             |
| PART I DEATH WAS CAUSED BY.  IMMEDIATE CAUSE (a)  Cardiac arrest  IMMEDIATE CAUSE (a)  DUE TO, OR AS A CONSEQUENCE OF  Conditions, if ony, which gave rise to immediate couse (o) stating the under-lying couse last.  DUE TO, OR AS A CONSEQUENCE OF  (b)  Coronary artery heart disease  DUE TO, OR AS A CONSEQUENCE OF  (c)  PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | DIVISION                                              | (YE       | Yes                                                                  | WN)     | WW2                                              | VAR OR DA     | ATES)               | 21/                     | 4-11                 | <b>-788</b>               |            |                     |                         | bara         | Beat             |                |               | iber                            |       |              |             |
| PART 2 DINER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 to 1  190 DATE OF OPERATION 196 CONDITION FOR WHICH OPERATION WAS PERFORMED?  210. AUTOPSY?  YES NO X  210. EXTERNAL CAUSE WAS UNDERLYING OR UNDERLYING OR CONTRIBUTING OR A.M. MONTH DAY YEAR CONTRIBUTING CAUSE OF DEATH P.M. 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | - TRANSIT PERMI<br>ENTAL HYGIENE,<br>OR REMOVAL.      |           | Condition<br>gave ris                                                | ATH War | AS CAUSED<br>IMMEDIATE<br>ny, which<br>immediate | BY.<br>E CAUS | E (a)(<br>DUE TO, O | Card:<br>RASA C<br>Coro | iac<br>conse<br>nar; | arre<br>QUENCE O<br>y art | ery        | neart               | dise                    | ase          |                  |                |               |                                 | SUC   | dden<br>dden | T AND DEATH |
| 210. EXTERNAL CAUSE WAS 210. EXTERNAL CAUSE WAS 210. TIME OF INJURY HOUR A.M. MONTH DAY YEAR CONTRIBUTING CAUSE OF DEATH P.M. 19 210. EXTERNAL CAUSE WAS 210. EXTERNAL CAUSE W | OF HEALTH A                                           | IFICATION |                                                                      |         |                                                  |               |                     |                         |                      |                           |            |                     |                         | ART 1 io     |                  |                |               |                                 |       |              |             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ARTAN<br>OR TO                                        | SICAL CER | UNDERLYING<br>CONTRIBUTION                                           | 46 0    | OR<br>CAUSE OF DI                                | EATH          | HOUR A.             | M. MON<br>M.            | VTH D                | 19                        |            | 9                   | OCCURR                  | ED LENTER    | NATURE OF IN     | JURY IN ITEA   | M 18 PART     | 1 OR PART                       |       |              | 1.0 (2)     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | AFTER DEATH, WITH THE STA<br>BALTIMORE, MARYLAND, 212 |           | death resulte<br>ACTUAL<br>SIGNATURE_<br>EXAMINER'S<br>(TYPE OR PRII | NAME    | Paul                                             | Sno           | w, w                | Accide<br>.D.           | em [                 | ) Sui                     | cide       | Hami TITLE (S D. Dp | specify)<br>ty<br>Memor | Under<br>MED | CALEXAA<br>Hospi | anner [        | ],            | DATE<br>SIGNED                  | 12/   |              |             |
| 20 1 Certify that the charge of the remains described above, held on Autopsy Inspection Inquiry and in my apinion death resulted from that roll round Accided Suicide Hamicide Undetermined manner,  ACTUAL SIGNATURE DATE 12/2/85  EXAMINER'S NAME Paul Snow, N.D Memorial Hospital, Cumberland Md  ADDRESS Memorial Hospital Cumberland Md  ADDRESS AND Memorial Hospital Cumberland Md                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | - 4 60<br>                                            | 24 FL     | Buria                                                                | 1       |                                                  |               |                     |                         |                      |                           |            |                     | су                      | Wes          | tern             | ort<br>R 25b R | All<br>EGISTR | COUNT<br><b>egar</b><br>AR'S SK | ny I  | Md.          | ATE         |
| Burial 12/5/85 St. Peters Cemetery Westernport Allegany Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ME (5))                                               | Bo        | oals Fu                                                              | ner     | il Ser                                           | vic           | e We                | stei                    | rnpo                 | ort, 1                    | Md.        | 21562               | CS                      | 1986         | 4                | Ma D           | evida         | in the                          | Bris. |              |             |

a come in the control of المراكب المراك Manager , Adding London .bk whomat from method wastern are to - 18/8/81 oll which is vive o cosmowly . 112

DHMH - 16 60M 7/B4 (VRA 15, 4) Leckemby Funeral Home Meyersdale, Pa. 1250 DATE REC'D. BY REC'D. B

250. DATE REC'D. BY REGISTRAR 256. REGISTRAR'S SIGNATURE

to aser at our Broivisi - incero A RD3 Meyersdals 11552 Seorge V. Payler Harry F. Lee ED 3 Layersdalo, Ra. 45138

Eurial 12/9/85 Union Cenetary Teyersdale Somerset Fa.

Lectedby function 1 Some Mayarate, Estado Company of the State of the

by

ompletely filled

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| ı | - STATE<br>REGISTRAR                                                   |                                                            |                                                       |                                                 | CERTIF   | ICATE OF DEATH             |              | REG. NO.                                             |                             | Million.                         |
|---|------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------|----------|----------------------------|--------------|------------------------------------------------------|-----------------------------|----------------------------------|
| 1 | DECEASED NAME<br>(TYPE OR PRINT)                                       | JOHN                                                       | 1000                                                  | RGE                                             |          | rer, Jr.                   |              | EMBER 7, 19                                          |                             | 3:20A                            |
| 3 | MALE                                                                   |                                                            | 4 RACE WHIT                                           | E                                               | JAN.     | DE BIRTH 14 DAY 1910 EA    |              | E (IN YEARS LAST BIRTHDAY)  y                        | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS.<br>HOURS MIN.   |
|   | BIRTHPLACE (STATE OF MARYLAND                                          |                                                            | USĄ                                                   | WHAT COUNTRY?                                   | MARRIE   |                            |              | TIMORE CITY <u>OR</u> COU<br>ALLEGANY                |                             | MD                               |
|   | O CITY OR TOWN OF D                                                    |                                                            | MEMORIA                                               | H FACILITY, GIVE STREET A                       | ADDRESS) | DR OTHER INSTITUTION       | (TYPE C      | SUAL OCCUPATION DE WORK FOR MOST OF WORKI TRED B & O | ING LIFE) INDUSTRY          | OF BUSINESS OR                   |
| 1 | USUAL RESIDENCE (IF NI<br>130 STATE<br>MARYLAND                        | 13b. COU<br>ALLE                                           | INTY                                                  | GIVE RESIDENCE BEFORE 130 CITY OR TOWN CUMBERLA |          | 136 INSIDE CITY LIMI       | 13. ST<br>20 | REET ADDRESS ZIP C<br>8 POLK STRE                    | 置えじ                         | 000                              |
| 1 | JOHN                                                                   |                                                            | G.                                                    | LESTER                                          | SR.      | 15 MOTHER'S MAIDE          |              | WIDDLE                                               | BEATTS                      | Y                                |
|   | MAS DECEASED EVE<br>(YES NO OR UNKNOWN)                                | (IF YES, G                                                 | VE WAR OR DATES)                                      | 166 SOCIAL SECU                                 |          | 17 INFORMANT<br>EVELYN LES | TER 20       | 8 POLK ST C                                          | UMBERLANI                   | MD.                              |
|   | Canditions, if a<br>gove rise to i<br>couse (a), sta<br>underlying cou | IMMEDIA<br>iny, which<br>mmediate<br>fing the<br>ise last. | ED BY:  ATE CAUSE (o)  DUE TO, O  (b)  DUE TO, O  (c) | R AS A CONSEQUE                                 | NGE OF   | ratory                     |              | SEASE OR CONDITION                                   | BETWEEN                     | MATE INTERVAL<br>OMSET AND DEATH |

FOR

196 CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [

CERTIFICATIO 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21d INJURY OCCURRED

226 SIGNATURE

(SPECIFY)

190 DATE OF OPERATION

216. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 21e PLACE OF INJURY

(AT HOME STREET, FACTORY OFFICE FARM ETC.)

21f LOCATION

21c HOW INJURY OC

STATE

a, that (I) (we) last

STATE

220.1 certify that (1) (this hospital) attended, the deceased from saw the deceased alive and the body after death

DEGREE

MEDICAL STAFF PHYSICIAN DIRECTOR PHYSICIAN 22c. DATE SIGNED

DR. WILLIAM P. IAMES

BURIAL

NOT WHILE

N. CENTRE ST. CHMBERLAND MARYLAND

ATTENDING

21502

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

230 BURIAL, CREMATION, REMOVA? 236 DATE 23c. NAME OF CEMETERY OR CREMATORY

73d. LOCATION CITY OR TOWN

COUNTY

AVALE ALLEGANY MARYLAND

REST LAWN CEMETERY 24 FUNERAL DIRECTOR NAME ADDRESS

CHMRERI

CITY OR TOWN

(aur) apinion death accurred on the date and have and from the couses stated

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| 1.            | FOR<br>STATE<br>REGISTRAR                                                        |                                                           | DEPART                                            |              | EALTH AND MENTAL HYG<br>ICATE OF DEATH |                         | G. NO.                     | La c            | ) or the                            |
|---------------|----------------------------------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------|--------------|----------------------------------------|-------------------------|----------------------------|-----------------|-------------------------------------|
|               | CEASED NAME FI                                                                   | RST                                                       | WIDDIE                                            | - 1          | AST                                    | 20 DATE OF DEA          |                            | AY YEAR         | 2b. HOUR                            |
| TITPE         | LUC                                                                              | Y Vi                                                      | rqinia                                            | LYO          | NS                                     | December                | 18, 198                    | 5               | 5:25<br>p.m                         |
| 3. SE         | X                                                                                | 4. RACE                                                   |                                                   | 5 DATE C     |                                        | 6. AGE (IN YEARS L      | AST BIRTHDAY)              | F UNDER 1 YEAR  | IF UNDER 24 HRS                     |
|               | Female                                                                           | Whit                                                      | e                                                 | nonth<br>Oct | . 28. 1908                             | 77                      | YRS.                       | ONTHS DAYS      | HOURS MIN,                          |
|               | IRTHPLACE (STATE OR FORE                                                         |                                                           | WHAT COUNTRY                                      | ? 8          |                                        | , ,                     | TY OR COUNTY C             | OF DEATH        |                                     |
|               | dest Vir <b>ni</b> n                                                             | ia U                                                      | .S.A.                                             | WIDOWE       | DINEVER MARRIED DINORCED               | Allegany                |                            |                 | MD.                                 |
|               | ITY OR TOWN OF DEATH                                                             | 11. NAME OF                                               | HOSPITAL, NURS                                    | ING HOME C   | OR OTHER INSTITUTION                   | 120. USUAL OCCU         | IPATION                    | 126. KIND O     | F BUSINESS OR                       |
| C             | umberland                                                                        | Memori                                                    | al Hospi                                          | tal &        | Medical Cente                          |                         | NET WORKING LIFE)          | INDUTRY         | n Home                              |
| #30.          | U.Va.                                                                            | HOME OR OTHER INSTITUTION COUNTY                          | GIVE RESIDENCE BEFO<br>13c. CITY OR TOV<br>Mays V | WN           | 13d INSIDE CITY LIMITS?<br>YES NO 🙀    |                         | ESS / ZIP CODE<br>2 Box 62 | 99              | 999                                 |
| 14. FA        | ATHER'S NAME                                                                     | MIDDLE                                                    | LAST                                              |              | 15. MOTHER'S MAIDEN NAM                | ME                      | DLE                        | LAS             | 51                                  |
| 1             | John                                                                             |                                                           | Lyo                                               |              | Lyda                                   | - 2                     |                            | Sche!           | 11                                  |
|               |                                                                                  | J.S. ARMED FORCES?<br>YES, GIVE WAR OR DATES)             |                                                   |              | 17 INFORMANT                           |                         | DDRESS                     | 0.0             |                                     |
|               | No                                                                               |                                                           | 234-70-                                           | 1310-4       | Robert Ly                              | on Rt.                  | #2 Box 6                   |                 |                                     |
|               | 18 CAUSE OF DEATH (E<br>PART I. DEATH WAS                                        | nter only one couse po<br>CAUSED BY<br>MEDIATE CAUSE (a)_ | er line for al, (b), a                            | de           | · daila                                | ne .                    |                            | BETWEEN         | MATE INTERVAL<br>ONSET AND DEATH    |
|               | Canditions, if any, what gove rise to immedicate (a), stating underlying cause I | ote the ost. (b)_                                         | PRAS A CONSEQUE                                   | JENCE D      | heart antiques                         | selin                   | rie                        | ALIN DADT I     |                                     |
| CERTIFICATION | 190 DATE OF OPERATION                                                            | orild                                                     | - cal                                             | on           | N WAS PERFORMED                        | 20s AUTOPSV7            | 20b. IF YES,<br>IN CERTIFY | WERE FINDIN     | NGS USED                            |
|               | 210. ACCIDENT WAS UNDERLY OR CONTRIBUTING CAUS                                   | E OF DEATH HOUR                                           | OF INJURY                                         | DAY YEAR     | 21c. HOW INJURY OCCURR                 | RED (ENTER NATURE O     | AVAL                       | ali i Oppari 21 | le                                  |
| MEDICAL       | 21d. INJURY OCCURRED  WHILE AT WORK NOT WHILE AT WORK                            | 21e PLACE                                                 | OF INJURY TREET, FACTORY, OFFICE                  | FARM, ETC )  | 211 LOCATION<br>STREET                 | ill city                | or town of                 | COUNTY          | STATE                               |
|               | 22a.1 certify that (1) (thi                                                      | s hospital) attended t<br>live on                         |                                                   | , an         | d that in (my) (aur) apinian a         | , tadeath accurred an 1 | he date and haur c         | and fram the    | that (I) (we) fast<br>causes stated |
|               | 226 SIGNATURE                                                                    | WZ                                                        | willing                                           | 1            | ATTENDING PHYSICIAN                    | MEDICAL DIRECTOR PH     | STAFF<br>IYSICIAN []       | 22c. DATE       | SIGNED                              |
|               | Dr. Robert                                                                       | Feddis                                                    | March !                                           | May a        |                                        | rand, MD                | 21302                      |                 |                                     |
|               | BURIAL, CREMATION, REA                                                           | 12/2                                                      |                                                   |              | emetery or crematory<br>anch Mem , Ga: | r Pete                  | fsburg,                    | W.Va.           | 26847                               |
| 24 Ft         | UNERAL DIRECTOR                                                                  | c Funeral                                                 | Home Pe                                           | tersb        | 17g, W. V. 1750 DAT                    | 3 1 1985.               | RAR 36 REGISTRA            |                 | URE                                 |

DHMH - 16 60M 7/84 (VRA 15, 4)

Tenini

Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Tenini
Ten

| 365190                                                                     | 1-            | FOR<br>STATE<br>REGISTRAR                                                                              | DEPARTA                                                   | STATE OF MARYLAND MENT OF HEALTH AND MENTAL HY CERTIFICATE OF DEATH | GIENE REG. NO                 | 32090                                                                       |
|----------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------|-------------------------------|-----------------------------------------------------------------------------|
| noy be                                                                     |               | CEASED NAME FIRST OR PRINT) Sc 077                                                                     | MAC                                                       | MiLLAN                                                              |                               | 0011 DAY YEAR 26 HOURS                                                      |
| age 4 may<br>rector, po                                                    | 3. SE         | PALE                                                                                                   | WHITE                                                     | 5. DATE OF BIRTH  NOV. 11, 1901                                     | 6. AGE (IN YEARS LAST BIRTH   | MONTHS DAYS HOURS MIN.                                                      |
| death. Pour                                                                | M             | ARY LAND                                                                                               | 76. CITIZEN OF WHAT COUNTRY?                              | MARRIED NEVER MARRIED WIDOWED DIVORCED                              | MALEG                         | ANY MD.                                                                     |
| urs after by the f                                                         | C             | ITY OR TOWN OF DEATH  UMBERLAND  ALRESIDENCE (IF NURSING HOME OR                                       | OF NOT IN SUCH FACILITY, GIVE STREET,  NURSING & CONV     | GHOMEOROTHER INSTITUTIONS ADDRESS (CUMBELLAND ALESCENT CENTER       | TYPE OF WORK FOR MOST OF      | WORKING LIFE) INDUSTRY                                                      |
| LAND 21 LAND 21 in 24 ha should be should be                               | MI            | STATE  RELIGION D BLUE  ATTERIS NAME                                                                   | A colotte was                                             | N 13d INSIDE CITY LIMITS?  YES NO                                   | 130. STREET ADDRESS           | VERAVE, 21502                                                               |
| E, MARY                                                                    |               | ADAM<br>VAS DECEASED EVER IN U.S. AR.                                                                  | MAL MILLS  MED FORCES? 166 SOCIAL SECU                    | AN MART                                                             | HA ADDRES                     | LEE                                                                         |
| cian and                                                                   |               | YES, NO ORNIKNOWN) (IF YES, GIV                                                                        | 214-07-                                                   | 1897 AGNES S                                                        | MITH, CUI                     | MBEK AND, MD.  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                 |
| ng physic<br>banpapar<br>remova                                            |               | 18 CAUSE OF DEATH (Enter on<br>PART I. DEATH WAS CAUSE<br>IMMEDIAT                                     | TE CAUSE (a)                                              | oxiz                                                                |                               | BETWEEN ONSET AND DEATH                                                     |
| W. PRESTO<br>hat the death<br>by the attendi<br>ose remotion, or           |               | Conditions, if ony, which gave rise to immediate couse (a), stating the underlying cause last          | DUE TO, OR AS A CONSEQUE                                  | <i>υ</i> ,                                                          |                               |                                                                             |
| RDS, 20<br>equires 1<br>n signed<br>Then ple<br>r to burio                 | NO            | PART 2 OTHER SIGNIFICANT C                                                                             | CONDITIONS CONTRIBUTING TO D                              | DEATH BUT NOT RELATED TO THE TER                                    | rminal disease or cond        | ITION GIVEN IN PART 11a                                                     |
| TAL RECO                                                                   | CERTIFICATION | 190 DATE OF OPERATION                                                                                  | 196. CONDITION FOR WHICH                                  | OPERATION WAS PERFORMED                                             | 200 AUTOPSY?                  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES NO |
| SICIAN: Tog physicicertificate                                             |               | ?1a. ACCIDENT WAS UNDERLYING ☐<br>OR CONTRIBUTING ☐ CAUSE OF DEA<br>(IF EITHER NOTIFY MEDICAL EXAMINER | HOUR A.M. MONTH DA                                        | AY YEAR                                                             | JRRED (ENTER NATURE OF INJURY | IN ITEM 18 PART 1 OR PART 2)                                                |
| DIVISION ING PHYS T attendir After this as the bu Ith and M orked or       | MEDICAL       | 21d. IN JURY OCCURRED  WHILE NOT WHILE AT WORK                                                         | 21s. PLACE OF INJURY LAT HOME, STREET, FACTORY, OFFICE, F | ARM, ETC.) 211 LOCATION<br>STREET                                   | CITY OR TOW                   | 'N COUNTY STATE                                                             |
| ATTENDI<br>aspital ar<br>ECTOR: A<br>d for use<br>it, of Heal<br>m 21 is m |               | saw the deceased alive an<br>abave, (I) (we) (did) (did no                                             | tol) attended the deceased from                           |                                                                     | n death accurred on the dat   | . 19, that (I) (we) lost to and hour and from the causes stated             |
| PITAL OR by the hy ERAL DIRE e detoche Stote Dep ANT: If the               |               | 22d. PHYSICIAN'S NAME (TYPE O                                                                          | alun                                                      | DEGREE<br>ATTENDING<br>PHYSICIAN<br>220 ADDRESS                     | MEDICAL STAFF                 | 221, DATE SIGNED                                                            |
| TO HOSPITAL retained by 11 TO FUNERAL should be det with the State         | 00            | P. 7                                                                                                   | FALMOS                                                    | 382 1                                                               | chleyst.                      | Curberland, Vld                                                             |
| BP                                                                         | 4             | BURIAL, CREMATION, REMOVAL                                                                             | EC. 14, 1985 On                                           | NAME OF CEMETERY OR GREMATORY  OK HILL CEMETER  250. D              | LY LONACO                     | MINE STATE  Sh. REGISTRAR'S SIGNATURE                                       |
| DHMH - 16 50M 4/82                                                         | -             | NAME - F.                                                                                              | as Here ADDRES                                            | maner Halas                                                         |                               | A F A SIGNATURE                                                             |

084534 こうない かんしょう かんしょう ARMAN THE AMERICAN TOTAL THE TRANSPORT Land of the CEMENE .... AND THE PERSON HAVE NEVERTHER THE PERSON OF THE PERSON OF

| 347048                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ١,            | FOR NATION                                                                       | WAL HW            |                | DEPA                                            |                | TE OF MARYLAI<br>HEALTH AND M |                        | IENE Ö S                                                  |                  | 2 8             | 4 3                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------------------------------------|-------------------|----------------|-------------------------------------------------|----------------|-------------------------------|------------------------|-----------------------------------------------------------|------------------|-----------------|------------------------------------|
| OFICAG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | L             | REGISTRAR LA                                                                     | AVALE,            | MD 21          | 502                                             | CERT           | FICATE OF DE                  | EATH                   | REG. N                                                    | 0.               |                 |                                    |
| a 11 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               | GEASED NAME                                                                      | FIRST             | VIAN           | MIDDLE                                          | UCILLE         | MATHEN                        | ٧Y                     | 20. DATE OF DEATH  DECEMBE                                |                  | 1985            | 26 HOUR                            |
| MOY MOY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1.58          |                                                                                  | - B-2A            | 4. RACE        |                                                 | 5. DATE        | OF BIRTH                      | VE A B                 | 6 AGE (IN YEARS LAST BIR                                  | THDAY)           | MONTHS DATS     |                                    |
| urs of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | -             | Female                                                                           |                   |                | ite                                             | 03             | / 27/                         | 1907                   | 78                                                        | YRS              |                 |                                    |
| 1 12 16                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 7g. B         | RTHPLACE (STATE OR I                                                             | FOREIGN           | 76. CITIZEN OF | A A                                             | MARR           | ED NEVER M.                   | ARRIED ORCED           | 9. BALTIMORE CITY C                                       |                  |                 | MD.                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1             | or town of DEA<br>Cumberla                                                       |                   | (IF NOT IN SU  | HOSPITAL, NU<br>JCH FACILITY, GIVE S<br>ED HEAR | TREET ADDRESS] | OR OTHER INSTI                | ITUTION                | 12a USUAL OCCUPAT<br>(TYPE OF WORK FOR MOST OF<br>Housewi | ION<br>DEWORKING | LIFE) INDUSTRY  | Home                               |
| (N3)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 13a M         | at residence firmurs<br>STATE<br>aryland                                         | 13b COUN          |                | 13c CITY OR                                     |                | 13d. INSIDE CIT<br>YES 🛣      | NO 🗌                   | 13e STREET ADDRESS<br>609 Cumb                            | ziP CO           | DE<br>and Arm   | ns/21502                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | rederick                                                                         | ,                 | MIDDLE         | Effing                                          | er             | Adel                          | IRST                   | WE                                                        |                  | Davis           | 5t                                 |
| 2 2 4/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 160           | WAS DECEASED EVER                                                                |                   |                | 166 SOCIAL                                      | SECURITY NO.   | 17 INFORMAN                   |                        | ADDR                                                      |                  |                 |                                    |
| 4 50 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               | NO OR UNKNOWN)                                                                   |                   |                | 220-3                                           | 4-139          | 9 Ann S                       | trieb                  | y - LaVal                                                 | e, l             |                 |                                    |
| erthcate<br>g physic<br>on pape<br>removal<br>event, it                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |               | 18 CAUSE OF DEAT<br>PART I. DEATH W                                              | AS CAUSE          |                | 0                                               | mona           | my Empl                       | olus                   |                                                           |                  | BETWEEN         | CIMATE INTERVAL<br>ONSET AND DEATH |
| orth co<br>motic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |               |                                                                                  |                   | DUE TO, C      | OR AS A CONSI                                   | OUENCE OF      | 1 11.                         | doubt-                 | 1                                                         |                  |                 | 5 years                            |
| by the off<br>Dy the off<br>Commons<br>other from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |               | Conditions, if any,<br>gove rise to im-<br>couse (a), statin<br>underlying cause | mediate<br>ng the | DUE TO, (      | OR AS A CONSI                                   | EQUENCE OF     | our fi                        | - pro-cys              |                                                           |                  |                 |                                    |
| Education of the color of the c | NO            | PART 2 OTHER SIGN                                                                | NIFICANTO RE      | CONDITIONS     | ONTRIBUTING                                     | TO DEATH BU    | T NOT RELATED 1               | TO THE TERM            | INAL DISEASE OR CON                                       | DITION G         | GIVEN IN PART I | 0                                  |
| n. no bermit ne prior                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | CERTIFICATION | 19a DATE OF OPERA                                                                | TION              | 196. CON       | DITION FOR WE                                   | HICH OPERA     | ON WAS PERFOR                 | RMED                   | 200 AUTOPSY?                                              | IN CERT          | ES, WERE FINDI  | OF DEATH?                          |
| physicia<br>physicia<br>rificate b<br>sl-transit<br>tal Hygie<br>m 18 sha                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |               | 21a. ACCIDENT WAS UNE                                                            | CAUSE OF DEA      | TH HOUR A      | OF INJURY<br>A.M. MONTH                         |                | 21c HOW INJ                   | URY OCCURR             | YES NO                                                    |                  | YES             | NO 🗌                               |
| UG PHYSIC<br>othending<br>ter this ce<br>is the buric<br>n and Men                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | MEDICAL       | 21d. INJURY OCCUR                                                                | RED               | 21e. PLACE     | P.M.<br>E OF INJURY<br>STREET, FACTORY, OF      | FICE, FARM ETC | 21f. LOCATION<br>STREET       | N                      | CITY OR TO                                                | wn               | COUNTY          | STATE                              |
| TTENDIN<br>pital or<br>TOR. Af<br>for use o<br>of Health                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |               | 220.1 certify that (1)<br>saw the decease<br>abave, (1) (we),(c                  |                   |                |                                                 |                | and that in (my) (            | , 19<br>our) opinian ( | death accurred on the d                                   | ate and h        |                 | that (I) (we) last                 |
| At OR A the has at DIRECteroched ste Dept.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |               | 22b. SIGNATURE                                                                   | eng               | 0 6            | Su                                              | mo             | DEGREE AT                     | ITENDING<br>HYSICIAN   | MEDICAL STA                                               | FF               | 12 DATE         | SIGNED                             |
| TO HOSPITALI<br>retained by the TO FUNERAL Should be defined with the State IMPORTANT:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               | 22d PHYSICIAN'S N.                                                               |                   | Brez           | a MD                                            |                | 22e ADDRESS                   |                        | SETON DRIVE                                               | . CUM            | BERLAND         | MD 21502                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | BURIAL, CREMATION,                                                               | REMOVAL           |                |                                                 |                | CEMETERY OR CE                | REMATORY               | 23d. LOCATION                                             |                  | COUNTY          | STATE                              |
| BP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |               | remation UNERAL DIRECTOR                                                         |                   | 12/0           | 6/85                                            | Smith          | burg Cr                       | remato                 | ry Smitht                                                 | urg              | Washi           | ng.,MD                             |
| DHMH - 16 60M 7/84<br>(VRA 15, 4)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1"            | John J.                                                                          | Hafe              | er. Jr         | Lat                                             | Tale.          | MD                            | DE                     |                                                           | JD. KEGI         | • WILLIAM DOWN  | undelle                            |

LAVELE, NO 21502 VIVIAN ERSE LEGISLE METERY PRODUCED 1985 11504 X AULEAN, COUNTY. Cumberland segren HEAST HOSFITAL HOUSEVILLE TONA House Meryland | Allegany | Complete x | Londred | Analysed | Sunday | Analysed THE STAVEL - Tologn miles of the control of STITE TIMES AN INC. STITCH CRIVE, CLASSERLAND, ID 21502 doing d. in fer, of. in Vale, on ... were the mint

| REGISTARY CUMBERTAINS, MOCIES INSTITUTE TO BEAT AND RESERVANCE IN INCREMENTAL COLOREST AND RESER | 008142                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1-     | FOR STATE 202                | Greene         | Stree               |                      | TMENT OF H     | EALTH AND MENTAL HYO          | GIENE O O               | <b>5</b>             | 2 0           | 9 0                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------------------------------|----------------|---------------------|----------------------|----------------|-------------------------------|-------------------------|----------------------|---------------|--------------------|
| Sale      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1. DÉ  |                              | FIRST          | a, M.               | MIDDLE               | 1              | AST                           |                         |                      | Y YEAR        | 2b HOUR            |
| TO SERVICE THAT SHAPE AND COUNTY OF BEATH  White                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 9 00 kg                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (TYPE  | OR PRINT)                    | Maraz          | p14                 | zaboth               | Mossi          |                               | Dogombox                | 20 1001              |               | 10:40pm            |
| Female    Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Female   Fe | à                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 3. SE  | (                            |                |                     | Zabetti              |                |                               |                         | SIRTHDAY) IF         | UNDER TYEAR   | IF UNDER 24 HRS    |
| The BRITHPIACE (STATISTICAL PROPERTY AND COUNTRY)  West Virginia   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | F      |                              |                | White               |                      |                |                               | 50                      |                      | NIHS DAYS     | HOURS MIN.         |
| West Virginia  West V | 000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |        |                              | OR FOREIGN 7   |                     | WHAT COUNTR          | Y2 8           |                               |                         |                      | FDEATH        |                    |
| DUAL WESTERN AND SECRET HOSPITAL NUMBERS FOR CITIES WESTERN FOR THE WESTERN FOR CITIES WE WESTERN FOR CITIES WESTERN FOR CITIES WESTERN FOR WESTERN FOR CITIES WESTERN FOR WESTERN FOR WESTERN FOR CITIES WESTERN FOR WE | # 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |        |                              | 2              |                     |                      | MARRIE         |                               | Alle                    | rany Col             | intv.         | AAD                |
| Conditions, if only, which with the part of the part o | de the de                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 40, C  | TY OR TOWN OF D              | EATH I         | 1. NAME OF          |                      | SING HOME      | - VT9/                        | 120. USUAL OCCUPA       | TION                 | 126 KIND OF   |                    |
| 18 STATE   S   | by the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Cı     | umberland                    | V. S           | Sacre               | d Heart              | Hospit         | al                            |                         |                      |               | 2                  |
| The part of the pa | do do                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 13a. S | AL RESIDENCE (IF NO<br>STATE | 13b COUN       | TY THER INSTITUTION | 13c. CITY OR TO      | NWC            | 13d. INSIDE CITY LIMITS?      | 13e.STREET ADDRESS      | ZIP CODE             |               | 101900             |
| Charles  Cha | hout file                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |        |                              | Miner          | al                  | Ft. As               | hby            | 7 100                         |                         | / 267                | 19 7          | 1177               |
| The management of the second from the second second from the s | Of 1 2 s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 14 FA  |                              | M              | NIDDLE              |                      |                | FIRST                         | MIDDLE                  |                      | LAST          |                    |
| THE CONTROL OF DEATH LETTER ONly and course per lime for 10, (b) apolic:    PART   DEATH WEST OF DEATH LETTER ONly and course per lime for 10, (b) apolic:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | p mb co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |        |                              |                | L.                  |                      |                |                               |                         | Dr. o o              | Burket        | t t                |
| Is CAUSE OF DEATH   Enter only one course per line for (o), (b), opd (c)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | nd co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |        |                              |                |                     |                      |                |                               |                         |                      |               |                    |
| PART L DEATH WAS CAUSED BY  MMEDIATE CAUSE (0)  QUIDTO, OR AS A CONSEQUENCE OF  BY  BY  BY  BY  BY  BY  BY  BY  BY  B                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | S. Po                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |        |                              |                | -                   |                      |                | Phyllis Malo                  | ne - WIley              | Ford, W              |               |                    |
| Image   Imag   | cate<br>nysici<br>poper<br>ny, th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |        | 18 CAUSE OF DEA              | ATH (Enter and | y ane cause pe      | r line far (a), (b), | and ici.       | 00                            | 0.0                     |                      | BETWEEN       | INSET AND DEATH    |
| Conditions, if only, which governmediate couse (a), stating the underlying cause lost.    PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TOTELATE BULNOT RELATED TO THE "ERMINAL DISEASE OR CONDITION GIVEN IN PART ITO    PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TOTELATE BULNOT RELATED TO THE "ERMINAL DISEASE OR CONDITION GIVEN IN PART ITO    PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TOTELATE BULNOT RELATED TO THE "ERMINAL DISEASE OR CONDITION GIVEN IN PART ITO    PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TOTELATE BULNOT RELATED TO THE "ERMINAL DISEASE OR CONDITION GIVEN IN PART ITO    PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TOTELATE BULNOT RELATED TO THE "ERMINAL DISEASE OR CONDITION GIVEN IN PART ITO    PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TOTELATE BULNOT RELATED TO THE "ERMINAL DISEASE OR CONDITION GIVEN IN PART ITO    PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TOTELATE BULNOT RELATED TO THE "ERMINAL DISEASE OR CONDITION GIVEN IN PART ITO    PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TOTELATE BULNOT RELATED TO THE "ERMINAL DISEASE OR CONDITION GIVEN IN PART ITO    PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TOTELATE BULNOT RELATED TO THE "ERMINAL DISEASE OR CONDITION GIVEN IN PART ITO    PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO THE PART ITO THE THE BULNOT RELATED TO THE "ERMINAL DISEASE OR CONDITION GIVEN IN PART ITO    PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO THE PART ITO THE THE BULNOT RELATED TO THE "ERMINAL DISEASE OR CONDITION GIVEN IN PART ITO    PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO THE PART ITO THE THE BULNOT RELATED TO THE "ERMINAL DISEASE OR CONDITION GIVEN IN PART ITO    PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO THE PART ITO THE THE BULNOT RELATED TO T | E 0000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |        |                              |                |                     | are                  | max            | Summer.                       | age                     |                      | -             |                    |
| DUE TO, OR AS CONSCIENCED FOR COLOR OF THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 160  PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TODALH BUYOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 160  PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TODALH BUYOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 160  PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TODALH BUYOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 160  PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TODALH BUYOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 160  PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TODALH BUYOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 160  PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TODALH BUYOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 160  PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TODALH BUYOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 160  PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TODALH BUYOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 160  PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TODALH BUYOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 160  PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TODALH BUYOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 160  PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TODALH BUYOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 160  PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TODALH BUYOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 160  PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 160  PART 2. OTHER SIGNIFICANT CONDITION GIVEN IN PART 160  PART 2. OTHER SIGNIFICANT CONDITION GIVEN IN PART 160  PART 2. OTHER SIGNIFICANT CONDITION GIVEN IN PART 160  PART 2. OTHER SIGNIFICANT CONDITION GIVEN IN PART 160  PART 2. OTHER SIGNIFICANT CONDITION GIVEN IN PART 160  PART 2. OTHER SIGNIFICANT CONDITION GIVEN IN PART | endir<br>endir<br>in, or<br>motic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |        | e to a                       |                | DUE TO, C           | OR AS A CONSE        | DUENCEOF       | 1 a Paren                     | in Line                 | int 1                | 100           |                    |
| Definition of the state of the  | ne de<br>move<br>r frou                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |        | gave rise to i               | mmediate       | (b)_                | (Chai                | Ju             | 147 Plaum                     | पा तरापा                | GEN I                | re            |                    |
| 196 DATE OF OPERATION   196 CONDITION FOR WHICH OPERATION WAS PERFORMED   206 AUTOPSY?   216 IF YES, WERE FINDINGS USED INCERTIFYING CAUSES OF DEATH? YES   NO NO   YES   YES   YES   NO NO   YES   YES   NO NO   YES   YES   NO NO   YES   YES   YES   NO NO   YES   YES   NO NO   YES      | by the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |        |                              |                | DUE TO, C           | OR AS PLUMSED        | 7 TO           | benia                         | Se ver                  | 2                    |               |                    |
| 196 DATE OF OPERATION   196 CONDITION FOR WHICH OPERATION WAS PERFORMED   206 AUTOPSY?   206 IF YES, WERE FINDINGS USED INCERTIFYING CAUSES OF DEATH? YES   NO     YES   NO   YES   NO     YES   NO     YES   NO     YES   NO     YES   NO     YES   NO     YES   NO     YES   NO     YES   NO     YES   NO   YES   NO     YES   NO     YES   NO     YES   NO     YES   NO     YES   NO     YES   NO     YES   NO     YES   NO     YES   NO   YES   NO     YES   NO     YES   NO     YES   NO     YES   NO   YES   NO     YES   NO     YES   NO     YES   NO     YES   NO   YES   NO     YES   NO     YES   NO     YES   NO   NO   YES   NO   YES   NO   YES   NO   NO   YES   YE   | ned pled                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |        | PART 2. OTHER SI             | GNIFICANT C    | ONDITIONS C         | ONTRIBUTING T        | O DEATH BUT    | NOT RELATED TO THE TERA       | MINAL DISEASE OR CO     | NDITION GIVEN        | IN PART 1cc   | 3                  |
| OR CONTRIBUTING CAUSE OF DEATH  P.M. 19  216 PLACE OF INJURY (AT HOME.STREET, FACTORY, OFFICE, FARM, ETC.)  217 ON TOWN THE AT WORK AT |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | NO.    |                              |                |                     |                      |                |                               |                         |                      | , Ha          |                    |
| OR CONTRIBUTING CAUSE OF DEATH  P.M. 19  216 PLACE OF INJURY (AT HOME.STREET, FACTORY, OFFICE, FARM, ETC.)  217 ON TOWN THE AT WORK AT | 9 . 5 . 9                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ICA]   | 19a DATE OF OPER             | RATION         | 196 CONE            | DITION FOR WHI       | CH OPERATIO    | N WAS PERFORMED               | - 1                     |                      |               | OF DEATH?          |
| OR CONTRIBUTING CAUSE OF DEATH  P.M. 19  216 PLACE OF INJURY (AT HOME.STREET, FACTORY, OFFICE, FARM, ETC.)  217 ON TOWN THE AT WORK AT | 20 - 20 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | RT     | AL ACCIDENTANAS              | INDERIVANC C   | 231 TIME            | OF INTRIBA           |                | Tale HOW MILLEY OCCUP         |                         |                      |               | NO 🗌               |
| 21d. INJURY OCCURRED  WHILE MOT WHILE ALTOWAY. OFFICE, FARM. ETC.)  21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM. ETC.)  21f. DCATION STREET  21f. CLATION STREET  21f. CLATION STREET  21f. CLATION STREET  22d. To To Town  COUNTY STATE  22d. To Town  22d. Town 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Phys<br>hiftco<br>Heror<br>ol Hy<br>ol Hy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |        |                              |                |                     |                      | DAY YEAR       | ZIC NOW INJOK! OCCOR          | RED FENTER NATURE OF IN | JURY IN ITEM IS PART | I I OKPARI 2) |                    |
| 22e I certify that (I) (this hospital) attended the deceosed from 7 - 0 . 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | rSIC<br>ling<br>cert<br>cert<br>cert<br>Aent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | OICA   |                              |                |                     |                      | 19             | 216 LOCATION                  |                         |                      |               |                    |
| 226. I certify that (I) (this hospital) attended the deceosed from 19 man and that in (myl (aur) opinion death accurred an the date and hour and from the causes stated obtained by the deceosed dive an 19 man and that in (myl (aur) opinion death accurred an the date and hour and from the causes stated obtained by the deceosed dive an 19 man and that in (myl (aur) opinion death accurred an the date and hour and from the causes stated obtained by the deceosed dive an 19 man and that in (myl (aur) opinion death accurred an the date and hour and from the causes stated obtained by the deceosed dive an 19 man and that in (myl (aur) opinion death accurred an the date and hour and from the causes stated obtained by the deceosed dive an 19 man and that in (myl (aur) opinion death accurred an the date and hour and from the causes stated obtained by the deceosed dive an 19 man and that in (myl (aur) opinion death accurred an the date and hour and from the causes stated obtained by the deceosed dive an 19 man and that in (myl (aur) opinion death accurred an the date and hour and from the causes stated obtained by the deceosed from 19 man and that in (myl (aur) opinion death accurred an the date and hour and from the causes stated obtained by the deceosed from 19 man and that in (myl (aur) opinion death accurred an the date and hour and from the causes stated obtained by the deceosed from 19 man and that in (myl (aur) opinion death accurred an the date and hour and from the causes stated obtained to the deceosed from 19 man and that in (myl (aur) opinion death accurred an the date and hour and from the causes stated obtained to the deceosed from 19 man and that in (myl (aur) opinion death accurred an the date and hour and from the causes stated obtained to the deceosed from 19 man and that in (myl (aur) opinion death accurred an the date and hour and from the causes stated obtained to the deceosed from 19 man and that in (myl (aur) opinion death accurred and the date and hour and from 19 man and the follows and the follows a | PHY<br>thend<br>the b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ME     | WHILE NOT                    | WHILE [        |                     |                      | CE, FARM ETC.) |                               | CITY OR                 | TOWN                 | COUNTY        | STAIL              |
| Saw the deceased alive an above, (I) (we) (did) (did not) view the body after death.    19   10   10   10   10   10   10   10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Afte<br>outh<br>mork                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |        |                              |                | al) attended t      | he decensed from     | m / 7 -        | 10 10 Or                      | - 10 / 2 -              | - JU- 19             | RI            | that (I) (we) last |
| DEGREE  2726 DATE SIGNED  2726 | TEN<br>TOR:<br>or us<br>of He                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |        | saw the dece                 | ased alive an_ | 12-                 | 7 () 19              |                | nd that in (my) (aur) opinian | death accurred an the   | date and haur a      |               |                    |
| ATTENDING MEDICAL STAFF PHYSICIAN DIRECTOR PHYSICIA | REC REC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |        |                              | (did) (did nat | ) view the bad      | y after death.       |                | DEGREE                        |                         |                      | 22c. DATE     | SIGNED             |
| John Mehanna, M.D.  23e. ADDRESS  John Mehanna, M.D.  909-B Seton Drive, Cumberland, MD 21502  23e. DATE (SPECIAL)  23e. DATE (SPECIAL)  Burial  1-2-86  Ft. Ashby Cemetery  Ft. Ashby - Mineral - West Va  24 FUNERAL DIRECTOR George-Upchurch Funeral Home, P.A.  25e. DATE REC'D. BY REGISTRAR' 25b. REGISTRAR' SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | the Date of the Da |        | ( ) (                        | X              | 7101                | 1-12-21-11           |                | ATTENDING PHYSICIAN           |                         |                      | 12-           | 31-85              |
| John Mehanna, M.D.  909-B Seton Drive, Cumberland, MD 21502  236. BURIAL, CREMATION, REMOVAL 236. DATE  (SPECIFY)  Burial 1-2-86 Ft. Ashby Cemetery Ft. Ashby - Mineral - West Va  24 FUNERAL DIRECTOR George-Upchurch Funeral Home, P.A. 256. DATE REC'D. BY REGISTRAR' 256. REGISTRAR' SSIGNATURE  24 FUNERAL DIRECTOR George-Upchurch Funeral Home, P.A. 256. DATE REC'D. BY REGISTRAR' SSIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | SPIT A by VER be do                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | -      | 224. PHYSICIAN'S             | NAME (TEPEOR   | PRINT)              | - Man                |                |                               |                         |                      |               | 7                  |
| PART OF CEMETERY OF CEMETER OF CEMETERY OF |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | -      | Johr                         | n Mehan        | na, M.I             | 0.                   |                | 909-B Seton                   | Drive. Cur              | berland              | 1. MD 2       | 21502              |
| BP Burial 1-2-86 Ft. Ashby Cemetery Ft. Ashby - Mineral - West Va                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 0 # 5 # ¥ ¥                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |        | BURIAL, CREMATIO             |                |                     |                      | E. NAME OF C   |                               | 23d LOCATION            |                      |               |                    |
| DHMH - 16 50M 4/83 24 FUNERAL DIRECTOR George-Upchurch Funeral Home, P.A. 250. DATE REC'D. BY REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 99BP999                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |        |                              |                | 1-2-8               | 6 F                  | t. Ash         | by Cemetery                   |                         | y - Mind             | eral -        | West Va            |
| TOURS OF THE PROPERTY OF THE P | DHMH - 16 50M 4/83                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |        |                              | George-        |                     |                      |                |                               |                         | R 25b. REGISTRA      |               |                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |        | 1 TOTAL TO                   | ~              |                     | HODALJ               | 3              | ·                             | HAN 6 16                | 200                  | 31,50         | A COLUMN           |

U.S. Course Platent.

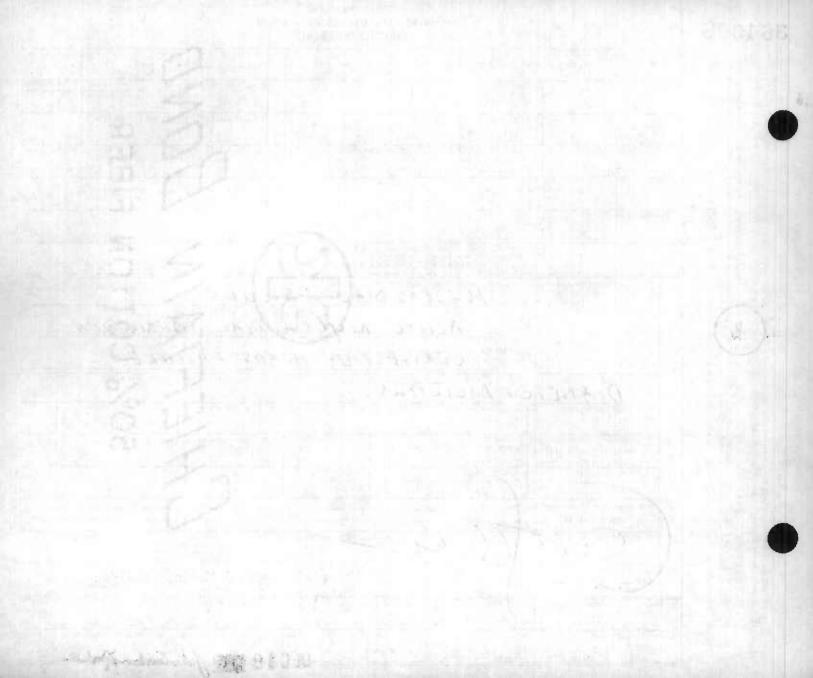
Describer 30, 1865

pathern decompositions

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1-            | FOR<br>STATE                                  |                                                           |                                            |                     | MENT OF H              | EALTH     | ARYLAND<br>I AND MENTA                                                |             |                                        | 3                | 2               | 3 4        | 1                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------|-----------------------------------------------------------|--------------------------------------------|---------------------|------------------------|-----------|-----------------------------------------------------------------------|-------------|----------------------------------------|------------------|-----------------|------------|---------------------------------|
| 351115                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               | REGISTRAR<br>CEASED NAME                      | FIRST                                                     | ME                                         | MIDDLE              | EXAMIN                 | ER'S C    | ERTIFICATE                                                            | OF DEA      |                                        | REG. NO.         |                 |            |                                 |
| # 4 4 5 F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |               | E OR PRINT)                                   | Robert                                                    | L                                          |                     | М                      | cKen      | LAG.                                                                  |             | 20. DATE KN<br>OF I<br>DEATH M         | NOWN XX          |                 | LO 1985    |                                 |
| RY, PLEASE<br>DIRECTOR.<br>DIRECTOR.<br>772 HOURS<br>ON STREET,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ³ Ma          |                                               | CE                                                        | Sept. 3,                                   | 1900                | 6. AGE IIN YEA         | oc LIETIN | IDER 1 YR. IF UN                                                      | DER 24 HRS. | 2c. DATE<br>PRONOUNCI<br>DEAD          | ED               |                 | DAY YE.    | 1.50                            |
| S FOR A S FOR  | FO            | RTHPLACE (STATE OR<br>REVGIL COUNTRY)         |                                                           | 76 CITIZEN OF W                            |                     |                        | WIDOW     |                                                                       | DRCED [     |                                        | legan            | У               |            | MD                              |
| PAGE<br>PAGE<br>S 2010                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1             | cumber 1                                      |                                                           |                                            | đ Hea               | art Ho                 | spi       | tal                                                                   | 12a USI     | WAL OCCUPA<br>MOST OF WORKIN<br>US TOO | TION (TYPE O     | F WORK          | CAOO       | BUSINESS<br>STRY                |
| 12136                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | DE S          | AL RESIDENCE (IF IN N                         | ATTE                                                      |                                            |                     | or IGWN                | g         | 134. INSIDE CITY LIMIT<br>YES NO                                      | Rt Rt       | REEL ADDRESS                           | bx 45            | 40              | 2153       | 32                              |
| 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1             | Leo<br>Leo                                    |                                                           |                                            | McKer               |                        |           | 15. MOTHER'S MA                                                       | ora         | MIDD                                   | C                | olem            |            |                                 |
| ALTIMO<br>AFTER J<br>SIVE PAS<br>TH FORES<br>MAGES IN<br>MISION I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |               | VAS DECEASED EVEL                             | (IF YE NOT                                                | TE FORCES?                                 | 212                 | -12-82                 | 36        | Mary M                                                                | onroe       | Rt.                                    | 1, Box           | 454             | Md.        | stbur                           |
| S CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURITH THE WORD "PENDING" IN PENCIL IN ITEM RED TO THE CHIEF MEDICAL EXAMINER ALONGE TO THE CHIEF MEDICAL EXAMINER ALONGE TO SHOULD BE USED AS A BURIAL. TRANSIT PEWART OF HEALTH AND MENTAL HYGIEN OF PROR TO BURIAL, CREMATION, OR REMOVAL.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | NO            | 2 OTHER SIGNIFICA                             | MAS CAUSED  IMMEDIATE  any, which immediate ig the under- | BY:  C AUSE (0)  DUE TO, O  (b)  DUE TO, O | Cerel<br>R AS A COM | oral va<br>nsequence c | F         | ar accide                                                             |             |                                        |                  |                 | BETWEEN OF | MATE INTERVAL<br>NSET AND DEATH |
| SHOULD SHOULD SHOULD SPE CHIEF ME E USED A URIAL, C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | CERTIFICATION | 19a. DATE OF OPER                             | ATION                                                     | 196 COND                                   | ITION FOR           | WHICH OPERA            | ATION W   | 'AS PERFORMED?                                                        |             |                                        |                  |                 | 20 AUTOP   |                                 |
| ON OF V                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | CAL CER       | 216. EXTERNAL CAL<br>UNDERLYING CONTRIBUTING  | OR<br>CAUSE OF D                                          |                                            | M. MONTH            | DAY YEAR               | 21c. HC   | OW INJURY OCCU                                                        | RRED (ENTER | NATURE OF INJUR                        | Y IN ITEM 18 PAI | RT 1 OR PART    | ?)         |                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | MEDICAL       | 214 INJURY OCCUP<br>WHILE NO.<br>AT WORK AT V | RRÉD<br>T WHILE      <br>WORK                             |                                            | OF INJURY           |                        |           | CATION<br>TREET                                                       | -           | CITY OR TOWN                           |                  | COUN            | IA         | STATE                           |
| TO MEDICAL EXAMINER: THI EXECUTE THE CREMINION OF A SHOULD BE FORWARD FOR THE STATE OF THE STATE | 1             |                                               | n I took charge                                           | ol the remains de la couses A              | Accident            | ngelo,                 |           | Homicide  TITLE (SPECIFY D. D. P. | Under       | Inquiry Dermined mann                  | ier,             | DATE<br>SIGNED. | 12/10      | √§5<br>0 21502                  |
| BP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (5            | JRIAL, CREMATION,<br>PECHYL Buria             |                                                           |                                            | 985St               | L.Jose                 | phs       | Cemete:                                                               | ry Mi       | dländ                                  |                  | egan            |            | d STATE                         |
| DHMH - 17<br>(VR A15 ME (5))<br>20M 4/B2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 24 E          | iveral director                               | Funer                                                     | al Hom                                     | e, Lor              | naconi                 | ng,I      | VId.   250. DA                                                        |             | 3 1985                                 | 25h REGIST       | roas file       | Nembeu     | a constant                      |

ave in more mart. 3, 19001 25 VIISOLEA All not (I de a granthout) your at 1, for high Tr. Concentie to a series of the series of t - and I treat to the land I was ANTHE CO. 13. 1815 Str. of Colony Bosen of Labrus. So norm Jumeral Some, setting of the

(VRA 15, 4)



DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| 166                                           | - STAT                 | E<br>STRAR                                                     |                               |                        | DEI AIKTI                             |                   | ICATE OF DEATH                                       |                                                    | G. NO.                  |                    |                                 |
|-----------------------------------------------|------------------------|----------------------------------------------------------------|-------------------------------|------------------------|---------------------------------------|-------------------|------------------------------------------------------|----------------------------------------------------|-------------------------|--------------------|---------------------------------|
| {1                                            | DECEASE<br>YPE OR PRIN |                                                                | TRUMAN                        |                        | ESLEY                                 |                   | ICHAELS                                              | DECEMBER                                           |                         | DAY YEAR           | 2b. HOUR 1:00A.                 |
| 3 5                                           | SEX Ma                 | le                                                             | 4.                            | RACE<br>White          |                                       | 5. DATE C         |                                                      | 6. AGE (IN YEARS LA                                | ST BIRTHDAY)            | MONINS DATE        | HOURS MIN                       |
| 35                                            | COUNTRY                | yland                                                          | FOREIGN 7b                    | CITIZEN OF US          | WHAT COUNTRY?                         | MARRIEI<br>WIDOWE | NEVER MARRIED                                        | 9. BALTIMORE CIT                                   |                         |                    | ٨                               |
| A401                                          | JMBER                  |                                                                | N                             | IEMORTA                | L HOSPIT                              | AL                | r other institution                                  | 120 USUAL OCCUP<br>CTYPE OF WORK FOR M<br>Sawmille | OST OF WORKING LI       |                    | er                              |
| 30 N                                          | Mary1                  | and                                                            | 13b COUNTY<br>Garre           |                        | Friends                               |                   | 13d. INSIDE CITY LIMITS?                             | 13e STREET ADDRE                                   | SS / ZIP CODE<br>Box 12 | 9 21               | 531                             |
| 1/0                                           | FATHER'S               | Victo                                                          | r =                           | DLE                    |                                       | naels             | 15. MOTHER'S MAIDEN NA<br>Esta                       | MIDD                                               |                         |                    | Sickle                          |
| and July 1990                                 | WAS DE                 | CEASED EVER<br>08 UNKNOWN)                                     | (IF YES, GIVE W               |                        | 166 SOCIAL SECU<br>215–18–98          |                   | Mrs. Goldie                                          | P.Michaels                                         | DDREROUTE<br>Frier      | l, Box<br>ndsville | 149<br>e, MD 2                  |
| event, the                                    | 18 C#                  | NUSE OF DEAT<br>ART I. DEATH V                                 | H (Enter only<br>VAS CAUSED I | BY:                    | line for (a), (b), and                | TM                | NEGATH                                               | 1E 381                                             | 0519                    | APPROX<br>BETWEEN  | MATE INTERVAL<br>ONSET AND DEAT |
| ol, cremation, or r<br>r other troumatic      | gove                   | litions, if any<br>rise to imi<br>e (a), stati<br>rlying cause | mediate<br>ng the             | (b)_                   | R AS A CONSEQUE                       |                   | PNEUT                                                | TONIA                                              |                         |                    |                                 |
| Hygiene prior to buring 8 shows ony injury, o | PART                   | 2 OTHER SIGNATE OF OPERA                                       | 1170                          | NB                     | SU                                    | ORI               | NOT RELATED TO THE TERM<br>PSS/OF<br>N WAS PERFORMED | 200 AUTOPSY?                                       | 206 IF YES              | S, WERE FINDIF     | OF DEATH?                       |
|                                               | 00.00                  | CCIDENT WAS UN                                                 | CAUSE OF DEATH                | 216. TIME O<br>HOUR A. | M. MONTH DA                           | Y YEAR            | 21c. HOW INJURY OCCUR                                | YES NO                                             |                         | PART : OR PART 2}  | NO [                            |
| ked or frem                                   | 21d In                 |                                                                | HILE                          | 21e PLACE (            | OF INJURY<br>SEET FACTORY, OFFICE, F. | ARM, ETC ]        | 211 LOCATION<br>STREET                               | CHYC                                               | DR TOWN                 | COUNTY             | STATE                           |
|                                               |                        |                                                                |                               |                        |                                       |                   |                                                      |                                                    |                         |                    |                                 |

14 FUNERALDRECTOR

220 AMEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502

230 BURIAL, CREMATION, REMOVAL Burial

THE PHYSICIAN'S NAME ITTE CHARLES

231 NAME OF CEMETERY OR CREMATORY 23b. DATE 12/18/85 Sand Spring Cemetery

Grantsville, MD

Friendsville, Garrett, MD TRA 256 REGISTRAR SSIGNATION

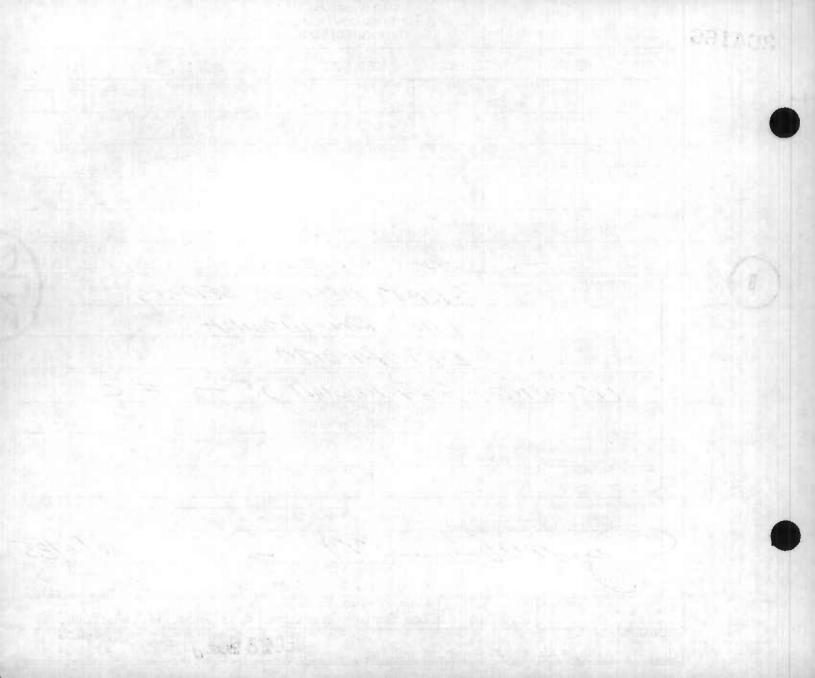
DHMH - 16 60M 7/84 (VRA 15, 4)

BP.

TO FUNERAL DIRECTOR:

should be detached for use as the burial-transit permit. Then with the State Dept. of Health and Mental Hygiene prior to be

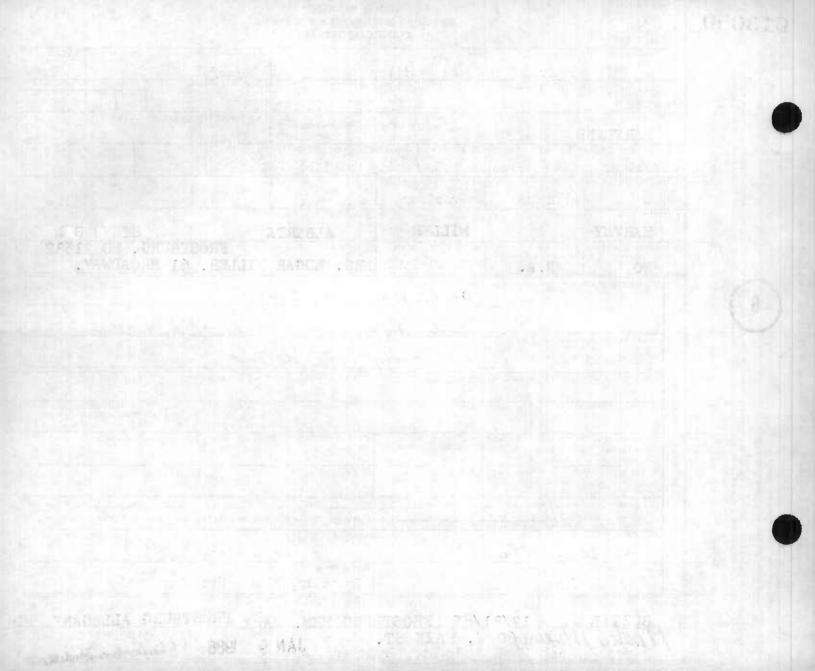
MPORTANT: If hem 21 is



| 3034                    | 1 - STA               |                                             |                                              | D                    |                                           | HEALTH AND MENTAL HY            | GIENE O O                                   | 5 2 3                      | 2 0                |
|-------------------------|-----------------------|---------------------------------------------|----------------------------------------------|----------------------|-------------------------------------------|---------------------------------|---------------------------------------------|----------------------------|--------------------|
| 000                     |                       |                                             | st                                           | MIDDLE               |                                           | LAST                            | 20. DATE OF DEATH                           |                            | 26 HOUR            |
| oy be<br>oge 3<br>deoth | (TYPE OR PR           | Cla                                         | arence                                       | E.                   | Miller                                    |                                 | Decen                                       | ber 11,198                 | 5 M                |
| moy<br>rer d            | 3 SEX                 |                                             | 4. RACE                                      |                      |                                           | OF BIRTH                        | 6. AGE (IN YEARS LAST BI                    | RTHDAY) IF UNDER I YEAR    | IF UNDER 24 HRS    |
| ector<br>rs of          |                       | Male                                        | Whi                                          | Lte                  | Ju                                        | ne 2, 1912                      | 73                                          | YRS DAYS                   | HOURS MIN          |
| 10 Po de                | 7a. BIRTHE            | LACE (STATE OR FOREIG                       | N 76 CITIZEN                                 | OF WHAT CO           | UNTRY? 8                                  |                                 | 9 BALTIMORE CITY                            | OR COUNTY OF DEATH         |                    |
| 2 50                    |                       | ryland                                      | U.                                           | S.A.                 | WIDOW                                     |                                 | Alles                                       | anv                        | MD                 |
| pel                     |                       | R TOWN OF DEATH                             |                                              |                      | NURSING HOME                              | OR OTHER INSTITUTION            | 12a. USUAL OCCUPA<br>(TYPE OF WORK FOR MOST | TION 126. KIND (           | OF BUSINESS OR     |
|                         |                       | ostburg                                     | 140                                          | ) E. M               | fain Str                                  |                                 | Pipefi                                      |                            | e Co.              |
| ould be                 | 130 STATI             | 1100                                        | iome or other institut<br>COUNTY<br>Allegany | 13c. CITY            | NCE BEFORE ADMISSION<br>OR TOWN<br>Stburg | 13d. INSIDE CITY LIMITS? YES NO | 13e STREET ADDRESS                          | MainSt., 2                 | 1532               |
| 2 sh                    |                       | R'S NAME<br>FIRST                           | WIDDLE                                       |                      | LAST                                      | 15. MOTHER'S MAIDEN NA          | ME                                          |                            |                    |
| (1)/6                   | 1                     | William                                     | T                                            | Mill                 |                                           | Jessie                          | WIDDLE                                      | Waddell                    | 51                 |
| 0 1                     | 160 WAS               | DECEASED EVER IN U                          |                                              | 5? 166 SOC           | AL SECURITY NO.                           | 17. INFORMANT                   | ADD                                         |                            |                    |
| e med                   | (YES, N               | NO (IF)                                     | YES, GIVE WAR OR DATES                       |                      | 07-5707                                   | Catherin                        | e Miller,                                   | Same as 1                  |                    |
| at, th                  | 18 0                  | PART I. DEATH WAS                           | nter only one couse                          | per line for to      | 1, (b), and (c).                          | 0                               |                                             | APPRO)<br>BFTWEEN          | ONSET AND DEATH    |
| 8                       |                       |                                             | AEDIATE CAUSE (0)                            |                      | testee Xi                                 | carlin                          | oma of                                      | he mostal                  |                    |
| 100                     |                       |                                             | DUE TO                                       | OR AS A CC           | INSEQUENCE OF                             |                                 |                                             |                            |                    |
| and of the same         | Co                    | nditions, if ony, wh                        | ich (b)                                      |                      |                                           |                                 |                                             |                            |                    |
| 100                     | CO                    | use (0), stating                            |                                              | OR AS A CO           | NSEQUENCE OF                              |                                 |                                             |                            |                    |
| # B *                   |                       |                                             | (c)                                          |                      |                                           |                                 |                                             |                            |                    |
| of the latest           |                       | There SIGNIFIC                              | ANT CONDITIONS                               | CONTRIBUT            | ING TO DEATH BU                           | NOT RELATED TO THE TERA         |                                             | NDITION GIVEN IN PART 1    | 0                  |
| ior t                   | 9 100                 | DATE OF OPERATION                           | Leco vy E                                    | NIDITION FOR         | WHICH OPERATION                           | ON WAS PERFORMED                | 200 AUTOPSY?                                | 20b. IF YES, WERE FIND!    | NCCHEED            |
| ws ar                   | CERTIFICATION 130°    | DATE OF OPERATION                           | 178. CO                                      | 140111014101         | WINCH OFERATIO                            | DIV WAS PERI ORMED              |                                             | IN CERTIFYING CAUSES       | S OF DEATH?        |
| Hygie<br>18 sho         | 210                   | ACCIDENT WAS UNDERLY                        | ING 171h. TIM                                | E OF INJURY          |                                           | 21c. HOW INJURY OCCUP           | YES NOTE NATURE OF IN                       | YES                        | NO [               |
| Mentol Hy               | 0.0                   | CONTRIBUTING CAUSE                          | OF DEATH HOUR                                | A.M. MON             |                                           |                                 | (11121111111111111111111111111111111111     | 541 10,7741 1 541 141 2,7  |                    |
| r He                    | 2                     | INJURY OCCURRED                             |                                              | P.M.<br>CE OF INJURY | 19                                        | 21f LOCATION                    |                                             |                            |                    |
| orked o                 |                       | ORK NOT WHILE                               |                                              |                      | Y, OFFICE, FARM, ETC.}                    | STREET                          | CITY OR TO                                  | OWN COUNTY                 | STATE              |
| deoli<br>is m           | 220.                  | l certify that (1) (this                    |                                              |                      |                                           | , 19                            | , to                                        |                            | that (I) (we) last |
| 21                      |                       | sow the deceased of obove, (1) (we) (did) ( | did not) view the bo                         | ody ofter deat       | h. 19, c                                  | nd that in (my) (our) opinion   | death occurred on the                       | date and hour and from the | couses stoted      |
| Dept<br>her             | 22b.                  | SIGNATURE                                   | 7                                            | 1                    | 1                                         | DEGREE                          | Cuspical                                    |                            | SIGNED             |
| IT. II                  |                       | 10                                          | 116                                          | -/                   | / 1                                       | ATTENDING PHYSICIAN             | MEDICAL STA                                 | ICIAN   12                 | 112/85             |
| STAN TAN                | 22d.                  | PHYSICIAN'S NAME                            | (TYPE OR PRINT)                              | C                    |                                           | 174 ADDRESS                     |                                             |                            |                    |
| with the State [        |                       |                                             | Schwartz                                     | M.I                  |                                           |                                 |                                             | rostburg.                  | Md.                |
| > ≤                     | 23a. BURIA<br>(SPECIF |                                             |                                              |                      |                                           | EMETERY OR CREMATORY            | 23d. LOCATION<br>CITY OR TOWN               | COUNTY                     | STATE              |
|                         | 1111                  | Burial                                      | Dec.                                         | 14185                | Eckha                                     | rt Cemetery                     |                                             | t. Allegan                 | y, Md.             |
| 60M 1/75                |                       | AL DIRECTOR                                 |                                              | AD                   | DRESS                                     | 75e.DA                          | TE REC'D. BY REGISTRAL                      | 954 REGISTRAR'S SIGNA      | TURE .             |
| 5 (4))                  |                       | Durst Fu                                    | neral H                                      | ome,                 | rostbu                                    | rg, Md. Utl                     | ABO INDO S                                  | man semigrand.             | A                  |

Marsh

The second secon ad all the work as I have been STATE .. COMPANY .. O The figure of the second of th AND THE RESERVE OF THE PROPERTY OF THE PROPERT



# FOR - STATE

### STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| 1 | REGISTRAR                                                                                      |                                                               | CERT                                                                   | IFICATE OF DEATH               | REG. NO                                                  |                                         |                               |                                   |    |
|---|------------------------------------------------------------------------------------------------|---------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------|-----------------------------------------|-------------------------------|-----------------------------------|----|
|   | 1 DECEASED NAME F                                                                              | RST M                                                         | IDDLE                                                                  | EAST                           | 20. DATE OF DEATH                                        | AONTH DAY                               | YEAR                          | 26 HOUR                           | -  |
|   |                                                                                                | ELLAN HA                                                      | RRY MORGE                                                              | RET                            |                                                          | 12 05                                   | 85                            | 10:03A M                          |    |
|   | 3 SEX                                                                                          | 4 RACE                                                        | 440                                                                    | E OF BIRTH                     | 6 AGE (IN YEARS LAST BIRTH                               | DAY) IF UP                              | HS DAYS                       | HOURS MIN.                        | _  |
| d | MALE                                                                                           | white                                                         | 06                                                                     |                                | 84                                                       | YRS.                                    | 52.5                          | ACIO.                             |    |
| 2 | BIRTHPLACE (STATE OR FORE                                                                      | IGN 76 CITIZEN OF V                                           | VHAT COUNTRY? 8.                                                       | RIED NEVER MARRIED             | 9 BALTIMORE CITY OR                                      | COUNTY OF                               | DEATH                         |                                   | -  |
| ١ | PA                                                                                             | USA                                                           |                                                                        | WED DIVORCED                   | Allegany                                                 |                                         |                               | MD.                               |    |
| 1 | 10 CITY OR TOWN OF DEATH CUMBERLAND                                                            |                                                               | OSPITAL, NURSING HOMI<br>HEACILITY, GIVE STREET ADDRESS!<br>L HOSPITAL | E OR OTHER INSTITUTION         | 120 USUAL OCCUPATION (TYPE OF WORK FOR MOST OF ROad Dept |                                         | 26. KIND O<br>NDUSTRY<br>COUL | of BUSINESS OR                    |    |
|   |                                                                                                |                                                               | GIVE RESIDENCE BEFORE ADMISSIO<br>13c. CITY OR TOWN<br>RIDGELEY        | 13d INSIDE CITY LIMITS?        | 13e.STREET ADDRESS /<br>PO BOX 80                        | ZIP CODE                                | 3                             | 9999                              | 6  |
| 7 | 14. FATHER'S NAME                                                                              | MIDDLE                                                        | LAST                                                                   | 15 MOTHER'S MAIDEN N           | MIDDLE                                                   | 6.355                                   | LAS                           |                                   | -  |
| 1 | Alfred N                                                                                       | Morgret                                                       |                                                                        | В                              | ertha True                                               |                                         | CA3                           |                                   |    |
| ١ | 160 WAS DECEASED EVER IN                                                                       | U.S. ARMED FORCES? FYES GIVE WAR OR DATES)                    | 166 SOCIAL SECURITY NO                                                 | . 17 INFORMANT                 | ADDRES                                                   | S                                       |                               |                                   |    |
|   | No                                                                                             |                                                               | 220-10-2212                                                            | Mr. Paul A.                    | Morgret, Ric                                             | dgeley,                                 |                               | - son                             |    |
|   | PART I DEATH WAS                                                                               | inter only one couse per l<br>CAUSED BY:<br>MEDIATE CAUSE (b) | ine for 101, 16% and 10.17                                             | RICULAR                        | 1 ACHYCAR                                                | DIA.                                    | APPROXI<br>BETWEEN            | IMATE INTERVAL<br>ONSET AND DEATH | _  |
|   | Conditions, if ony, w                                                                          |                                                               | AS A CONSEQUENCE OF                                                    | anan Aten                      | Distace                                                  |                                         |                               |                                   |    |
|   | gove rise to immed                                                                             | iote                                                          | AS A CONSEQUENCE OF                                                    | young or say                   |                                                          |                                         |                               |                                   |    |
|   |                                                                                                | Sculitis I                                                    | ATTRIBUTING TO DEATH B                                                 | US TO CHE TER                  | MINAL DISEASE OR COND                                    | ITION GIVEN I                           | N PART 100                    | D                                 |    |
| , | 190 DATE OF OPERATIO                                                                           | N 196. CONDIT                                                 | IN FOR WHICH OPERAL                                                    | ION WAS PERFORMED              | YES NO                                                   | 206. IF YES, WE<br>IN CERTIFYING<br>YES |                               |                                   |    |
| ) | 00.00                                                                                          | SE OF DEATH HOUR A.A                                          | A. MONTH DAY YEA                                                       | AR .                           | RRED (ENTER NATURE OF INJURY                             | IN ITEM 18 PART 1                       | OR PART 2)                    |                                   |    |
|   | GREONINBUTING CAU GIF EITHER NOTIFY MEDICAL 21d. INJURY OCCURRED WHILE AT WORK AT WORK AT WORK | LAT HOME, STRE                                                | OF INJURY<br>SET FACTORY OFFICE FARM ETC.)                             | 211 LOCATION<br>STREET         | CITY OR TOW                                              | N                                       | COUNTY                        | STATE                             | ĺ. |
|   | 22a   certify that (I) (th                                                                     | s hospital) ottended the                                      | deceased from                                                          | , 19                           | , to                                                     | . 19_                                   |                               | that (I) (we) last                |    |
|   | sow the deceased obove, (1) (we) (did)                                                         | (did nat) year the body of                                    | after death.                                                           | and that in (my) (our) opinion | n death accurred on the dat                              | e and hour and                          | d from the                    | causes stated                     |    |
|   | 22b. SIGNATURE                                                                                 | Kanjith                                                       | 0                                                                      | DEGREE ATTENDING PHYSICIAN     | MEDICAL STAFF                                            | :<br>AN 🗍                               | 22c DATE                      | 2/6/8                             | -  |
|   | DR. RANJI                                                                                      |                                                               |                                                                        | 22e ADDRESS Memo               | rial Hospita<br>erland, MD 2                             | 1 Medic<br>1502                         | al Bl                         | ldg.                              |    |

MPORTANT: If Item 2 DHMH 16 60M 7/B4

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Burial 24 FUNERAL DIRECTOR (VRA 15, 4)

23b DATE 230 BURIAL, CREMATION, REMOVAL 12-08-1985

23c NAME OF CEMETERY OR CREMATORY Piney Plains Cemetery

23d LOCATION Flintstone

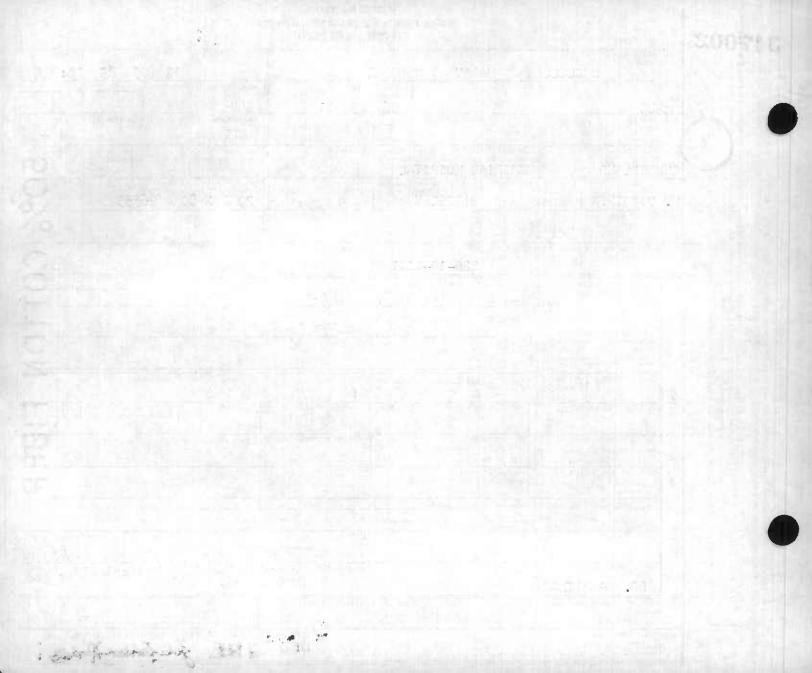
Allegany

James F. Scarpelli, Cumberland, MD 21502

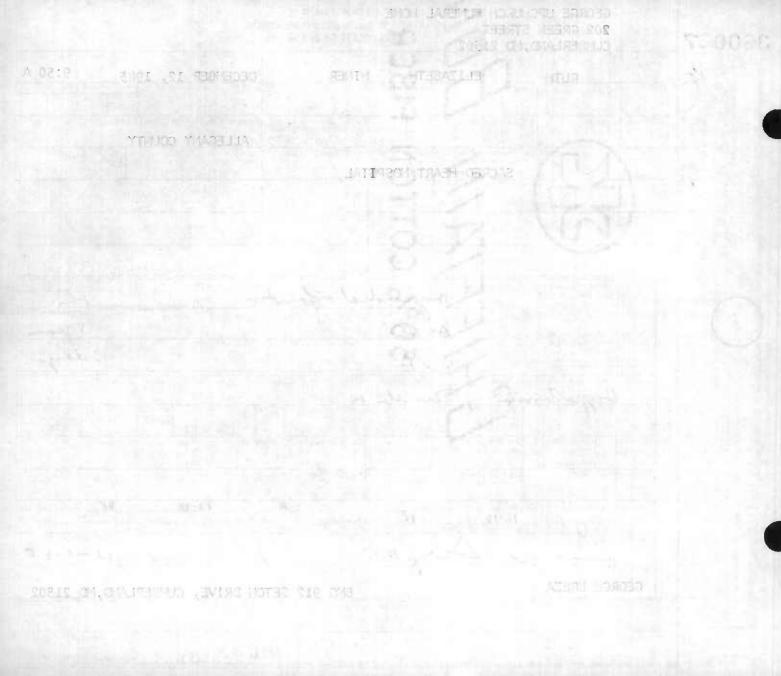
25q. DATE REC'D. BY REGISTRA

ULL

MD



|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | COD                                   |                              |                | FUNERAL H                |             |                                        | 3 5                         | 3                              | 2 3                         | 3 U                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------------------------------|------------------------------|----------------|--------------------------|-------------|----------------------------------------|-----------------------------|--------------------------------|-----------------------------|--------------------|
| מיכיםם                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1 -           | STATE 202                             |                              | STREET         |                          |             | EALTH AND MENTAL HYG<br>ICATE OF DEATH | •                           |                                |                             |                    |
| 50027                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1. DE         | REGISTRAPCUMB                         | ERLAND                       | MD 21          | MIDDLE                   |             | AST                                    | REG. NO                     | O. MONTH DAY                   | YEAR 7b                     | . HOUR             |
| できしか                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |               | OR PRINT)                             | RUTH                         |                | ELIZABETH                |             | NINER                                  | DECEMBER 1                  | 2. 1985                        |                             | 9:50 A             |
| bood de de                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 3. SE         |                                       |                              | 1 RACE         |                          | S. DATE C   | F BIRTH                                | 6 AGE (IN YEARS LAST BIR    | THDAY) IF U                    | NDER 1 YEAR IF              | UNDER 24 HRS       |
| urs of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | E             | MAI E                                 |                              | WHITE          |                          | JUNE        | 18,1919                                | 66                          | YRS                            |                             | IOURS MIN.         |
| 2 ho                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 70 B          | RTHPLACE (STATE OR                    | FOREIGN                      | b. CITIZEN OF  | WHAT COUNTRY?            | 8<br>MARRIE | NEVER MARRIED                          | 9 BALTIMORE CITY O          | R COUNTY OF                    | DEATH                       |                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | ARYLAND<br>TY OR TOWN OF DEA          | ATH                          | U.S.A          | HOSDITAL NILIDSIN        | WIDOWE      | DIVORCED DIVORCED                      | ALLEGANY 126 USUAL OCCUPATI |                                | 26 KIND OF B                | MD                 |
| Filed with                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | -Cı           | IMBERL AND                            |                              | SACR           | ED HEART                 | HOSPO       |                                        | TYPE OF WORK FOR MOST C     | DE WORKING LIFE)               | RESTAL                      |                    |
| 36                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 13a S         | AL RESIDENCE IN NURS                  | 136 COUN                     |                | 13c CITY OR TOW          |             | 13d. INSIDE CITY LIMITS?               | RT. 6, I                    | ZIP CODE                       |                             |                    |
| mer m                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 14 E          | ARYLAND<br>THER'S NAME                | LALFO                        | SANY           | I PINTO                  |             | YES NO D                               |                             | NER KOAI                       | ) / 215                     | 000                |
| wo W                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |               | FIRST                                 | N                            | AIDDLE         | WINTER                   |             | FIRST                                  | MIDDLE                      |                                | CDADENIC                    | OTE TAL            |
| 900                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |               | WRESSEL<br>VAS DECEASED EVER          |                              |                | 16b. SOCIAL SECU         | IRITY NO.   | 17 INFORMANT                           | ADDRE                       | ESS                            | GRABENS                     | SIEIN .            |
| medic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (             | VES NO OR UNKNOWN)                    | I IF YES, GIVE               | WAR OR DATES)  | 215-42-4                 | 457         | JOHN H. NINE                           | R - ADDRESS                 | SAME A                         | s #13 /                     | ABOVE.             |
| the factor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |               | 18 CAUSE OF DEAT<br>PART I. DEATH W   | H (Enter onl                 | y one couse pe | r line for (a), (b), an  | dici        | .1 / /                                 |                             |                                |                             | TE INTERVAL        |
| 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |               | PARTI. DEATH W                        |                              | E CAUSE (a)    | myo                      | eard        | in injoint                             | in.                         |                                | 1-6                         |                    |
| 3)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |               |                                       |                              | DUE TO, C      | R AS A CONSTOUR          | NCE OF      | - 1                                    |                             | AF                             | 70                          | 12.                |
| 100                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |               | Conditions, if ony gove rise to imi   | mediate                      | (b)            | 133 14                   |             |                                        |                             |                                |                             | rang               |
| of the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               | cause (a), statir<br>underlying cause | last                         | DUE TO, O      | R AS A CONSEQUE          | NCE OF      |                                        |                             |                                | 3 de                        | de.                |
| 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |               | PART 2 OTHER SIGI                     | NIFICANT C                   |                | ONTRIBUTING TO I         | DEATH BUT   | NOT RELATED TO THE TERM                | AINAL DISEASE OR CON        | DITION GIVEN                   | IN PART To                  |                    |
| 2 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | NO.           | yrs                                   | urter                        | non'           | , Der                    | lite        | 4                                      |                             |                                |                             |                    |
| 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | CERTIFICATION | 190 DATE OF OF                        | TION                         | 196. COND      | ITION FOR WHICH          | OPERATIO    | N WAS PERFORMED                        | 20a AUTOPSY?                | 20b. IF YES, W<br>IN CERTIFYIN | ERE FINDING:<br>G CAUSES OF | S USED<br>F DEATH? |
| 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ERTI          | 71a. ACCIDENT WAS UNI                 | DERLYING []                  | 21b. TIME C    | OF IN ILIRY              |             | 21c. HOW INJURY OCCUR                  | YES NO                      | YES [                          |                             | ио 🗌               |
| 10 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |               | OR CONTRIBUTING                       | CAUSE OF DEAT                | HOUR A         | M. MONTH DA              | AY YEAR     | The view in sport occor.               | VED TENTER NATURE OF 11430  | KI IN IIEM IQ PAKI             | ORFARIZ)                    |                    |
| of the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | MEDICAL       | 21d. INJURY OCCUR                     |                              | 21e. PLACE     | OF INJURY                |             | 21f LOCATION                           | CITY OR 10                  | had b                          | COUNTY                      | STATE              |
| rked                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | \$            | AT WORK NOT WE                        | HILE                         | (AT HOME ST    | REET, FACTORY, OFFICE, F | ARM, ETC )  | ZIKEEI                                 | CITORIO                     |                                | COUNT                       | SIAIL              |
| the state of the s |               | 220.1 certify that (1)                |                              | 10 - 10        |                          |             | , 19                                   |                             |                                |                             | ot (I) (we) lost   |
| 212                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |               | saw the deceas<br>abave, (1) (we) (   | ed alive on<br>did) (did nat | view the bady  | rafter death.            |             | d that in (my) (aur) apınian           | death accurred an the de    | ate and hour an                |                             |                    |
| 2 D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |               | 226. SIGNATURE                        |                              | -              | 1.                       | m           | ATTENDING .                            | MEDICAL STAI                | FF                             | 12 DATE SIC                 |                    |
| N N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |               | 22d. PHYSICIANIS N.                   | AME (TYPE OF                 | PRINT          | 500                      | 1112        | PHYSICIAN D                            | DIRECTOR   PHYSIC           | IAN 🛮                          | 12-12                       |                    |
| 54 %                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |               | GEORGE B                              | REZA                         |                |                          |             |                                        | ON DRIVE C                  | I MADEDI A                     | NID MID                     | 21502              |
| 4 4 M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |               | URIAL, CREMATION,                     |                              | 236. DATE      | 23 c 1                   | NAME OF C   | EMETERY OR CREMATORY                   | ON DRIVE, C                 | UNDEKLA                        | עיי, טאי                    | 21302              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | B             | SPECIFY) URIAL                        |                              | 12-16          | -85 ST.                  | AMBR        | OSE CEMETERY                           | CRESAPTOWN                  | N-ALLEG                        | ANY-MAI                     | RYLAND             |
| 5 60M 7/84                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |               |                                       | EORGE                        | -UPCHUR        | CH FUNERA                |             | E, PA 250 DAT                          | E REC'D. BY REGISTRAR       |                                |                             |                    |
| 15, 4)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 20            |                                       |                              |                | RLAND, MA                |             |                                        | EC 23 1985                  | 11 m. m 24                     | visson-170                  | indesse            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               |                                       |                              |                |                          |             |                                        |                             |                                |                             |                    |



| 36            | 0025                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 1.0           | STATE<br>REGISTRAR                       |                                                | M                                                                   |                             | EXAMIN                                 | ER'S C      | ERTIFICA                          | ATE OF         | DEAT                | IH .           | REG. NO.            | bica         | 0                    |                                 |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|------------------------------------------|------------------------------------------------|---------------------------------------------------------------------|-----------------------------|----------------------------------------|-------------|-----------------------------------|----------------|---------------------|----------------|---------------------|--------------|----------------------|---------------------------------|
|               | LESS. S. E. E. S. E.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | L (TY         | CEASED NAM<br>PE OR PRINT)               | JAMES                                          |                                                                     |                             | NORMAN                                 |             | LAST                              |                | 2                   | OF E           | ATED [              | 12 16        | 19                   | 1650                            |
|               | ARY, PLEASE<br>L DIRECTOR.<br>COUR FILES.<br>V 72 HOURS<br>ION STREET,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | b i           | ale                                      | Cau                                            | 5. DATE OF BIRTI                                                    | 909                         | 6. AGE (IN YEA<br>AST BIRTHDA<br>76 YR | MONTH       |                                   | UNDER 24       | AIN P               | DEAD DEAD      | D 12                | 2 16         | 19-                  | 2d. HOU 165                     |
| •             | VECESS<br>UNERA<br>FOR 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | F             | IRTHPLACE (S<br>DREIGN COUNTRY)<br>W. WA |                                                | USA                                                                 |                             |                                        | WIDOW       |                                   | DIVORCED       |                     | Allega         |                     |              |                      | M                               |
|               | PAGE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Cu            | mber lan                                 | d                                              | 11. NAME OF HO                                                      | Heart                       | Hospi                                  | tal         | ER INSTITUTIO                     | DN II          | POR MC              | Mech           | ION (TYPE OF SUIFE) | WORK 12b     | OR INDUST<br>UTOD    | USINESS<br>TRY<br><b>eale</b> : |
| . 21201       | RETAIN<br>RETAIN<br>RECORD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Ma            | Tyland                                   | IN FPE                                         | OR OTHER HISTITUTION,                                               |                             | Sapewin                                | r           | 13d. INSIDE CITY I                |                |                     | N. B           | el Ai               | 531 <b>1</b> | . 21                 | 502                             |
| ORE, MD       | DEATH.<br>GES1,2<br>M PM 3<br>M PM 3<br>NP 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |               | Alonz                                    | 0                                              | MIDDLE                                                              | Nor                         |                                        |             | Jenni                             | ie             | NAME                | MIDDI          |                     | R            | lober                | ts                              |
| BALTIMO       | RS AFTER<br>GIVE PA<br>WITH FOR<br>DIVISION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 16a.          | NO. OR UNKNO                             |                                                | E WAR OR DATES)                                                     | 214                         | -05-72                                 | 284         | Ruth                              |                | nan                 |                | address<br>erlan    | d, M         |                      |                                 |
| N ST.,        | ENE DI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               | 18 CAUSE C<br>PART I DI                  | F DEATH (Enter of<br>EATH WAS CAUSI<br>IMMEDIA | nly one cause per li<br>ED BY: (ATE CAUSE (o)                       |                             |                                        |             | a                                 |                |                     |                |                     |              | APPROXIMA<br>BEWENDE | M AND DEATH                     |
| W. PRESTON ST | (NEW PARTY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |               |                                          | ns, if any, which<br>se to immediat            | F                                                                   | R AS A COR                  | ing myo                                | card        | ial in                            | farcti         | ion                 |                |                     |              | 4 mon                | ths                             |
| . 201 W.      | EXAME<br>EXAME<br>D MEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |               | lying cas                                |                                                | (c)                                                                 | Corona                      | ry arte                                | ery h       |                                   |                |                     |                |                     |              | years                | F                               |
| CORDS         | SE EXE<br>ENDING<br>MEDICAL<br>AS A BU<br>ALTH AN<br>CREMATA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | CERTIFICATION | Park                                     | insonism                                       | S CONTRIBUTING TO DEAT                                              | H BUT NOT REL               | ATEO TO THE TERMI                      | NAL OISEASE | OR CONDITION GI                   | IVEN IN PART 1 | l (a).              |                |                     |              |                      |                                 |
| VITAL RI      | SHOULD BOOKD "FEN CHIEF ME USE USED AS USED AS UNIT OF HEAL USED AS UNIT |               |                                          | OPERATION                                      |                                                                     |                             | WHICH OPERA                            | ATION W     | AS PERFORME                       | ED?            |                     |                |                     |              | 20 AUTOPSY           | NOXX                            |
| ONOF          | DIVISION OF VITAL RECORDS, 201 S CERTIFICATE SHOULD BE EXCUTE RITING THE WORD "PENDING" IN FROED TO THE CHIEF MEDICAL EX ES SHOULD BE USED AS A BURRAL E DEPARTMENT OF HEALTH AND MOI PRICK TO BURRAL, CREMATION.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |               | UNDERLYING<br>CONTRIBUTI                 | NG CAUSE OF                                    | DEATH P.                                                            | Μ.                          | DAY YEAR                               |             | W INJURY O                        | CCURRED        | (ENTER NA           | TURE OF INJURY | IN ITEM 18 PART     | 1 OR PART 2  |                      |                                 |
| DIVIS         | THIS CERT<br>WARDED<br>WARDED<br>PAGE 3 SI<br>TATE DEP.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | MEDICAL       | 21d INJURY O                             |                                                |                                                                     | OF INJURY<br>CTORY, PARM, I |                                        |             | CATION                            |                |                     | CITY OR TOWN   |                     | COUNTY       |                      | STATE                           |
| •             | TO MEDICAL EXAMINER: T<br>SECULT THE CERTIFICATE.<br>PAGE 4 SHOULD BE FORM<br>TO FUNERAL DIRECTOR: P<br>AFTER DEATH, WITH THE ST<br>BALTIMORE, MARYLAND, 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4             |                                          | fy that I took char                            | ge of the remains dural cause (** ********************************* | Accident                    |                                        | Autaps      | y , Ir<br>Hamicide<br>TITLE (SPEC |                | Undeter             | Inquiry To     | er .                | my opinio    | 12/4                 | 6/8                             |
|               | MEDIC<br>ECUTE TH<br>GE 4 SH<br>GE 4 SH<br>TER DEAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |               | EXAMINER'S<br>(TYPE OR PRI               | NAME Pau                                       | l Snow, N                                                           | 1.D.                        |                                        |             |                                   | moria          |                     |                | umber 1             |              | 1d                   |                                 |
| 07/84         | Bb                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 230.8         | Burial                                   | TION, REMOVAL                                  | Dec. 19,                                                            |                             | NAME OF CEM                            |             |                                   |                | 23d. LOC<br>CITY OF | TOWN           | and A               | COUNTY       |                      | STATE                           |
| 25M           | DHMH - 17<br>(VR A15 ME (5))                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |               | UNERAL DIREC                             | m G. Ki                                        | ght Cum                                                             | berla                       | and, M                                 | D           | 70                                |                | C Z                 | EGISTRAR       | 256 REGISTR         | AR'S SIGI    | ATURE.               | حاديمان                         |

.: lliam

Jul13, 1909

ALU

Res Lachanic Autobealer

. 206 M. Bel Air Dr. 21502

the property of the same of the same of

Roberts Jennie llorman. osnola 214-05-7284 Ruth Morman Cumberland, 1D

Burial Dec. 19, 1985 illerest Burial P. Cumberland Allegany ED William G. Kight Cumberland, LD

DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** 

| REG. N        | 10.   |     |      |        |
|---------------|-------|-----|------|--------|
| DATE OF DEATH | MONTH | DAY | YEAR | 2b. HO |
|               | 12    | 23  | 85   | 213    |

| 1                     |          | CEASED NAME FIRST MIDDLE  OR PRINT!  RUTH ISER                                                                                      |             | AIDDLE                                                               | LAST                                                   |                                                                                                                             | 20 DATE OF DEATH MONTH DAY YEAR 26. HOUR                                                            |             |                                                         |               |             |                    |                                   |       |  |
|-----------------------|----------|-------------------------------------------------------------------------------------------------------------------------------------|-------------|----------------------------------------------------------------------|--------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|-------------|---------------------------------------------------------|---------------|-------------|--------------------|-----------------------------------|-------|--|
| 1                     | (TYPE    |                                                                                                                                     |             | OATES                                                                |                                                        |                                                                                                                             | 12                                                                                                  | 23          | 85                                                      | 2137          | 7 M         |                    |                                   |       |  |
| 1                     | 3 SEX    | 1101                                                                                                                                | 4 RACE      |                                                                      |                                                        | 5. DATE OF BIRTH                                                                                                            |                                                                                                     |             | 6 AGE (IN YEARS LAST BIRTHDAY) IF UNDER I YEAR IF UNDER |               |             |                    |                                   |       |  |
|                       | 0        | FEMALE                                                                                                                              |             | WHIT                                                                 | WHITE 06                                               |                                                                                                                             | 11                                                                                                  | 1900        | 85                                                      | YR:           | MONTHS      | DAYS               | HOUR5                             | MIN,  |  |
| Q                     |          | RTHPLACE (STATE OR FOREIGN 76 CITIZEN OF WHAT COUNTRY? 8                                                                            |             | 8 AAA DDIE                                                           | MARRIED NEVER MARRIED                                  |                                                                                                                             | 9 BALTIMORE CITY OR COUNTY OF DEATH                                                                 |             |                                                         |               |             |                    |                                   |       |  |
| 1                     | ALLEGANY |                                                                                                                                     |             | USA                                                                  |                                                        | WIDOWE                                                                                                                      | WIDOWED DIVORCED                                                                                    |             | ALLEGANY COUNTY CUMBERLAND MD.                          |               |             |                    |                                   |       |  |
| 7                     | CUI      | CITY OR TOWN OF DEATH  11. NAME OF HOSPITAL, NURSING HOM (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  MEMORIALHOSPITAL CI        |             |                                                                      |                                                        | CUN                                                                                                                         | OR OTHER INSTITUTION  120 USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE  RETTRED SCHOOL T |             |                                                         |               | GLIFE) IN   |                    |                                   |       |  |
|                       | 13a. S   | L RESIDENCE (IF NURS<br>TATE<br>YLAND                                                                                               | 136 COUN    |                                                                      | GIVE RESIDENCE BEFORE<br>13c CITY OR TOWN<br>CUMBERLAN | V                                                                                                                           | 13d. INSIDE (                                                                                       | NO [        | 13e STREET ADDRES                                       |               |             | PACA               | STRE                              | EET   |  |
| 1                     | 14 FA    | THER'S NAME FIRST MIDDLE LAST  I. W. ISER                                                                                           |             |                                                                      |                                                        |                                                                                                                             | S MAIDEN NA/<br>FIRST<br>THER IN                                                                    | NAME LAST   |                                                         |               |             |                    |                                   |       |  |
| i                     |          | WAS DECEASED EVER IN U.S. ARMED FORCES? 16b. SOCIALS                                                                                |             | 16b. SOCIAL SECUI                                                    | RITY NO.                                               | 17 INFORMANT ADDRESS                                                                                                        |                                                                                                     |             | 11101                                                   | HOLIK         |             |                    |                                   |       |  |
| ۱                     |          | (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) 219-14-7028                                                                        |             |                                                                      |                                                        | 028                                                                                                                         | CICHARD HILL 4062 OLD ORCHARD ROAD YORK PA.                                                         |             |                                                         |               |             |                    |                                   |       |  |
| MEDICAL CERTIFICATION |          | 18 CAUSE OF DEATH IEnter only one couse per line for 101, (b) and 101.  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE 10)           |             |                                                                      |                                                        |                                                                                                                             |                                                                                                     | monary      | fdera                                                   |               |             | APPROXI<br>BETWEEN | MATE INTER<br>ONSET AND           | RVAL  |  |
|                       |          | DUE TO, OR AS A CONSEQUENCE OF                                                                                                      |             |                                                                      |                                                        |                                                                                                                             |                                                                                                     |             |                                                         | 2             |             |                    |                                   |       |  |
|                       |          | Conditions, if ony, which gove rise to immediate couse (a), stating the underlying couse lost.  (b)  DUE TO, OR AS A CONSEQUENCE OF |             |                                                                      |                                                        |                                                                                                                             |                                                                                                     |             |                                                         |               |             |                    |                                   |       |  |
|                       | NOI      | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110    |             |                                                                      |                                                        |                                                                                                                             |                                                                                                     |             |                                                         |               |             |                    |                                   |       |  |
|                       | TIFICAT  | 19a DATE OF OPERA                                                                                                                   | TION        | 196 CONDITION FOR WHICH OPERATION                                    |                                                        |                                                                                                                             | N WAS PERFO                                                                                         |             |                                                         |               |             |                    | RE FINDINGS USED CAUSES OF DEATH? |       |  |
|                       |          | 210. ACCIDENT WAS UND OR CONTRIBUTING (IF EITHER NOTIFY MEDI                                                                        | CAUSE OF DE | AIH                                                                  | M. MONTH DA                                            | Y YEAR                                                                                                                      | 21c HOW IP                                                                                          | JURY OCCURE | RED (ENTER NATURE OF I                                  | NJURY IN ITEM | IS PART I O | R PART 2)          | h,                                |       |  |
|                       | MEDIC    | 21d INJURY OCCURE                                                                                                                   | HILE [      | 21e. PLACE OF INJURY  (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                        |                                                                                                                             | 211 LOCATI                                                                                          |             | CITY OR TOWN COUNTY STATE                               |               |             |                    |                                   | STATE |  |
|                       |          | 22a.1 certify that (1) (this hospital) attended the deceased from                                                                   |             |                                                                      |                                                        |                                                                                                                             |                                                                                                     |             |                                                         |               |             |                    |                                   |       |  |
| 1                     |          |                                                                                                                                     |             |                                                                      |                                                        | DEGREE  MD ATTENDING MEDICAL STAFF PHYSICIAN DIRECTOR PHYSICIAN []  721. DATE SIGNED  1219 1219 1219 1219 1219 1219 1219 12 |                                                                                                     |             |                                                         |               |             |                    |                                   |       |  |
|                       |          | DR. V. RANJITHAN                                                                                                                    |             |                                                                      | MEMORIAL HOSPITAL CUMBERLAND MD.                       |                                                                                                                             |                                                                                                     |             |                                                         |               |             |                    |                                   |       |  |
| _                     | 0.0      |                                                                                                                                     |             |                                                                      |                                                        |                                                                                                                             |                                                                                                     |             |                                                         | THE LEV.      |             |                    |                                   |       |  |
|                       | 230 B    | URIAL, CREMATION,                                                                                                                   | KEMOVAL     | 23b. DATE                                                            | 73c. N                                                 | AME OF C                                                                                                                    | EMEIERY OR                                                                                          | CREMATORY   | 23d. LOCATION                                           |               |             |                    |                                   |       |  |

DHMH - 16 60M 7/84

BP.

TO FUNERAL DIRECTOR: should be detoched for with the State Dept. of H IMPORTANT: If them 21

SILCOX-MERRITT (VRA 15, 4)

24 FUNERAL DIRECTOR

BURIAL

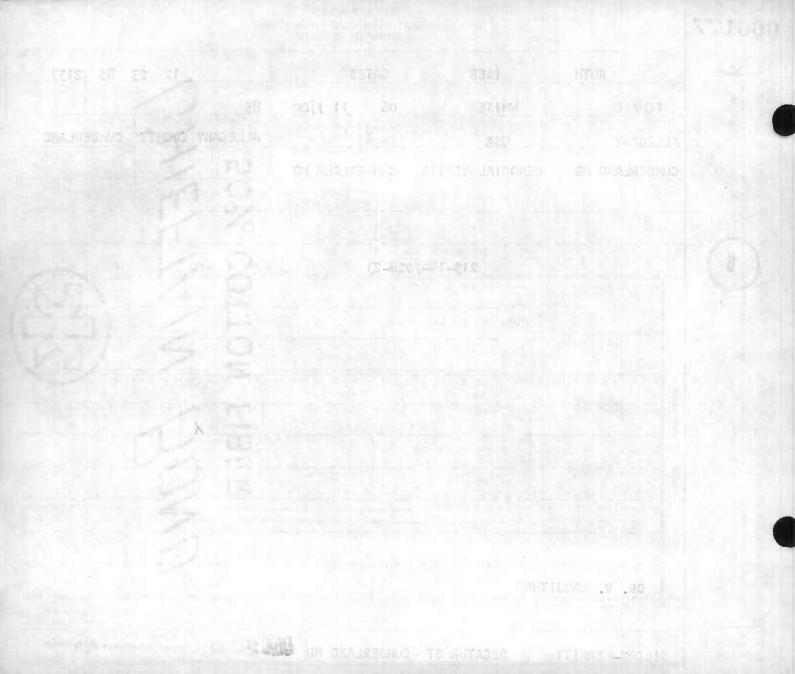
DECATUR ST

DEC 26 1985 QUEENS POINT CEMETERY

CUMBERLAND MD

KEYSER MINERAL WEST VIRGINIA

250, DATE REC'D. BY REGISTRAR 250. REGISTRAR'S SIGNATURE



ld b

(VRA 15, 4)

DEPARTMENT OF HEALTH AND MENTAL HYGIENE - STATE CERTIFICATE OF DEATH REGISTRAR DECEASED NAME 20. DATE OF DEATH MONTH 7h HOUR TYPE OR PRINTS 1615 **DECEMBER 26, 1985 EMORY** OSTER ARNOLD 4 RACE A AGE LIN YEARS LAST BIRTHDAY! 3 SEX 5 DATE OF BIRTH IF UNDER 1 YEAR YE 05 OT n 80 WHITE MALE TO BIRTHPLACE ISTATE OR FOREIGN 76. CITIZEN OF WHAT COUNTRY? 9 BALTIMORE CITY OR COUNTY OF DEATH MARRIED NEVER MARRIED ALLEGANY COUNTY CUMBERLAND IISA WIDOWEDT DIVORCED [ 10 CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION 12h KIND OF BUSINESS OR (TYPE OF WORK FOR MOST OF WORKING LIFE) INDUSTRY ALLEGANY COUNTY NURSING HOME CUMBERLAND machine operator macaroni USUAL RESIDENCE (IF NURSING HOME OR OTHER Allegany 136.SIREET ADDRESS / ZIP CODE Route 4 Oldtown Road/21502 13d INSIDE CITY LIMITS? Cumberland 14 FATHER'S NAME 15 MOTHER'S MAIDEN NAME LAST Charles Oster Anna L. Boor 160 WAS DECEASED EVER IN U.S. ARMED FORCES? 166 SOCIAL SECURITY NO. 17 INFORMANT TO OR UNKNOWN) LIE YES GIVE WAR OR DATEST Mr. Clayton B. Oster Jr., Cumberland, MD 213-64-9828 18 CAUSE OF DEATH (Enter only one couse per line for ALAb), and PART L DEATH WAS CAUSED BY IMMEDIATE CAUSE (0) DUE TO OR AS A CONSEQUENCE OF Conditions, if onv. which gove rise to immediate couse (a), stating the underlying couse PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART LID **IFICATION** 196 CONDITION FOR WHICH OPERATION WAS PERFORMED 20b. IF YES, WERE FINDINGS HISED IN CERTIFYING CAUSES OF DEATH? 21g. ACCIDENT WAS UNDERLYING 21b. TIME OF INJURY 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) HOUR A.M. MONTH DAY YEAR OR CONTRIBUTING CAUSE OF DEATH MEDICAL LIF EITHER NOTIFY MEDICAL EXAMINER 211 LOCATION 21d INJURY OCCURRED 21e PLACE OF INJURY COUNTY STATE AT HOME STREET, FACTORY OFFICE, FARM ETC ) WHILE NOT WHILE 220.1 certify that (1) (this haspital) attended the deceased from\_ sow the deceased alive an\_ and that in (my) (our) opinion death accurred on the date and hour and from the causes stated above, (1) (we) (did) (did not view the body after death 22b. SIGNATURE DEGREE 22c. DATE SIG ATTENDING MEDICAL DIRECTOR PHYSICIAN [ 22d. PHYSICIAN'S NAME RAN.ITTHAN 230 NAME OF CEMETERY OR CREMATORY 23d. LOCATION 12-28-1985 Sunset Memorial Park Cumberland Allegany 24 FUNERAL DIRECTOR 250 DATE REC'D. BY REGISTRAR 256. REGISTRAR'S SIGNATURE DHMH - 16 60M 7/84 James F. Scarpelli, Cumberland, MD 21502

|                    | 0.5400                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                       | FOR<br>STATE                     |                      | D                          | STATE STATE OF I                              | TE OF MAR         |                      | HYGIENE S              | 3                   | , 2             | 0 3        | 1                          |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|----------------------------------|----------------------|----------------------------|-----------------------------------------------|-------------------|----------------------|------------------------|---------------------|-----------------|------------|----------------------------|
| 3                  | 64128                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                       | REGISTRAR                        |                      | MED                        | ICAL EXAMIN                                   | ER'S CER          | RTIFICATE            |                        | REG. NO.            |                 |            |                            |
|                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       | CEASED NAME OR PRINT)            | E FIRST              |                            | WIDDLE                                        | LAST              |                      | Ze. DATE               | KNOWN XX            | MONTH D         | AY YEAR    | 2h HOUR                    |
|                    | 1. 85 S. P.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (111)                 | CORPRINT                         | DURGTI               | HY LENORA                  | 05                                            | TER               |                      | DEATH                  | MATED               | 12              | 16 19 85   | 0755                       |
|                    | PLEASE<br>CTOR<br>FILES.<br>HOURS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 3. SEX                |                                  | 4. RACE              | 5. DATE OF BIRTH           | 6 AGE IN YE                                   | ARS IF UNDER      |                      |                        |                     | MONTH D         | DAY YEAR   | 2d HOUR                    |
| ,                  | S S S S S S S S S S S S S S S S S S S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1                     | ema le                           | Cau                  | 9 5 PAY                    | 15 /0 YEAR                                    |                   | DAYS HOURS           | MIN PRONOU             |                     |                 | 16 19 85   | 0755,                      |
|                    | ECESSA<br>INGRAL<br>WITHIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 7a BI                 | RTHPLACE (S<br>REIGN COUNTRY)    | MD                   |                            |                                               |                   | _                    | RIED X                 |                     |                 | OF DEATH   |                            |
|                    | WHIND OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 10 CI                 | TY OR TOWN                       | OF DEATH             | 11. NAME OF HOSP           | ITAL, NURSING HOME                            |                   |                      | 120 USUAL OCCU         | PATION (TYPE O      | F WORK 12h      |            |                            |
|                    | PAGE PAGE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | c                     | umberla                          | and                  | Rt 4 Bo                    | x 35 01dto                                    | wn Road           | d                    | retired                | RKING LIFE)         | В               |            |                            |
| 100                | A SEEDER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                       |                                  |                      |                            | RESIDENCE BEFORE ADMISSE<br>136. CITY OR TOWN |                   | INSIDE CITY LIMITS?  | Ise STREET ADDR        | ESS                 |                 | 215        | 103                        |
|                    | る名物を置く                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | M                     | aryland                          | 1 Alle               | eany                       | Cumberla                                      | nd Y              | ES NO Q              |                        |                     | town F          | Road       |                            |
| 2                  | PE-28                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 14 FA                 | THER'S NAME                      |                      | MIDDLE                     | LAST                                          | 15.               | MOTHER'S MAID        | - /                    |                     |                 | LAST       |                            |
| 9                  | 205581-A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 16a. V                | VAS DECEASE                      | DEVER IN U.S. A      |                            | 16b. SOCIAL SECURIT                           | Y NO. 17.         | INFORMANT            | MIIIa L.               | ADDRESS             |                 |            |                            |
| 44.00              | E STORY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (4)                   | ES, NO, OR UNKNO                 | OWN) (IF YES, GR     | /E WAR OR DATES]           | 214-07-11                                     | 77 M              | ۱r. Clayt            | on Oster,              | Cumber              | land,           | MD-bı      | rother                     |
|                    | S D S Ja                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                       | 18 CAUSE C                       | F DEATH (Enter of    | only one couse per line f  | or (o), (b), ond (c).)                        |                   | CHALL.               |                        |                     |                 | APPROXIMAT | E INTERVAL<br>ET AND DEATH |
| 3                  | 200 S 00 Z                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 7.3                   | PARITO                           | IMMEDI               | ATE CAUSE (0) Card         | io-pulmona                                    | ry arre           | est                  |                        |                     |                 | Sudde      | n                          |
| -                  | MOVA<br>MOVA<br>MOVA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 12.1                  | Health St                        |                      |                            | S A CONSEQUENCE                               | OF.               |                      |                        |                     |                 |            |                            |
| 0                  | RE A PER E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                       |                                  |                      | (b)Acut                    | e congesti                                    | ve hear           | rt failu             | re                     |                     |                 |            |                            |
| 3                  | SE LES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1                     | couse (o                         | ) stoting the unde   | DUE TO, OR A               | S A CONSEQUENCE                               | OF .              |                      |                        |                     |                 |            |                            |
| 6                  | ON A EX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                       | Tyling coo                       | 356 1031.            | (c)_Car                    | cinoma. le                                    | ft brea           | ast with             | me tas tas             | is                  |                 |            |                            |
| č                  | A A B B A G G G                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       | PART 2 OTHER SI                  | IGNIFICANT CONOITION | S CONTRIBUTING TO DEATH BU | IT NOT RELATED TO THE TERM                    | INAL DISEASE OR ( | CONDITION GIVEN IN P | ART 1 (a)              |                     |                 |            |                            |
| MICE STATES BECOME | SEA SECTION OF THE SE | No.                   | Hypert                           | tension:             | Diabetes                   |                                               |                   |                      |                        |                     |                 |            |                            |
| 9                  | 387837                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | MEDICAL CERTIFICATION | 190. DATE OF                     | OPERATION            |                            | ON FOR WHICH OPER                             | ATION WAS F       | PERFORMED?           |                        |                     | 2               | 0 AUTOPSY  | ?                          |
|                    | ASE SE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | E                     |                                  |                      | 034148                     |                                               |                   |                      |                        |                     |                 | YES 🗍      | NO 🕱                       |
| 2                  | W H W H W H W H W H W H W H W H W H W H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | E .                   |                                  |                      |                            |                                               | 21c HOW           | INJURY OCCURR        | ED (ENTER NATURE OF IN | DURY IN ITEM 18 PAR | RT 1 OR PART 2) | 120 (1)    | 110 4                      |
| 2                  | A HE DE LA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | AL A                  | UNDERLYING                       | OR OR                |                            |                                               |                   |                      |                        |                     |                 |            |                            |
|                    | SHOPE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 20                    |                                  |                      | 21e PLACE OF               | INJURY (AT HOME.                              | 211. LOCAT        | ION                  |                        |                     |                 |            |                            |
| 5                  | TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN SECURIFICATE SHOULD BE EXECUTED WITHING THE WORD "PENDING" IN PENCIL PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. THE PAGE 3 SHOULD BE USED AS A BURRAL "RRAN AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL BALTIMORE, MARYLAND, 21201 PRIOR TO BURRIAL, CREMATION, OR REM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ME                    | WHILE<br>AT WORK                 | NOT WHILE            | STREET, FACTO              | RY, FARM, ETC.)                               | STREET            |                      | CITY OR TO             | )WN                 | COUNTY          |            | STATE                      |
|                    | ATE, ORV                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                       | 22a. I certi                     | fy that Hook cho     | rge of the remoins descr   | ibed obove, held on                           | Autopsy [         | , Inspectio          | on X. Inquiry          | XXX ond             | in my opinio    | n          |                            |
|                    | NE HOLES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                       | death result                     | d from Not           | urol couses                | Accident Su                                   | cide .            | Homicide .           | Undetermined m         | onner ,             |                 |            |                            |
|                    | NE LERT WITH WITH WAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                       | 6                                | ~                    | //                         | /)                                            |                   | TITLE (SPECIFY)      |                        |                     |                 |            |                            |
|                    | A THE CHAIR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                       | SIGNATURE.                       | 10                   | al                         | hon                                           | M.D               | Doty                 | MEDICAL EXAM           | MINER               | DATE            | 12/16      | /85                        |
|                    | MEDICA<br>CUTE TH<br>SE 4 SH<br>FUNERA<br>FER DEAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                       | EV ALL DIENG                     |                      |                            | 77                                            |                   |                      |                        |                     |                 |            |                            |
|                    | F. F. C. F.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                       | (TYPE OR PRI                     | NT) Da               | ul Snow M                  | D                                             | ADD               | RESMemori            | al Hospita             | al. Cum             | berlar          | nd_        |                            |
|                    | 5X45A8                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 23a.Bl                | BATTMORE CITY OR COUNTY OF DEATH |                      | 144                        |                                               |                   |                      |                        |                     |                 |            |                            |
| 07/E               | 84 BP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (2                    | Bu                               | urial                | 12-18-1985                 | Sunset M                                      | emoria:           | l Park               | Cumber                 | rland /             | Allea           | any M      |                            |
| 25M                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 24. FU                |                                  | TOR                  |                            |                                               |                   | 250. DATE            |                        |                     |                 |            |                            |
|                    | (VR A15 ME (5))                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |                                  | . Scarp              | elli, Cumbe                | rland, MD                                     | 21502             | DECA                 | 0 1005 4               | the David           | ser fan         | delle      | 4                          |

FOR

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| 1             | REGISTRAR                                                  |                          |                                          | CERTIF   | ICATE OF DEATH                  | REG. NO                     | ).           |                      |                                   |
|---------------|------------------------------------------------------------|--------------------------|------------------------------------------|----------|---------------------------------|-----------------------------|--------------|----------------------|-----------------------------------|
|               | CEASED NAME FIRST                                          |                          | MIDDLE                                   | ι        | AST                             |                             | HTMON        | DAY YEAR             | 26. HOUR P. M                     |
|               |                                                            | rles I                   | Robert Par                               | tric     | k                               | December                    | 17.          | 1985                 | 4.35 P                            |
| 3. SE         |                                                            | 4. RACE                  | 5.                                       | DATEC    |                                 | 6. AGE (IN YEARS LAST BIRTH | IDAY)        | MONTHS DAYS          | IF UNDER 24 HRS                   |
|               | Male                                                       | Cau.                     | A                                        |          | £ 15. 1908                      | 77                          | YRS          | IMONINS DATS         | HOURS MIN                         |
|               | IRTHPLACE (STATE OR FOREIGN                                | 76. CITIZEN OF           | WHAT COUNTRY? 8                          |          | D NEVER MARRIED                 | 9. BALTIMORE CITY OF        | COUN         | TY OF DEATH          |                                   |
|               | Maruland                                                   | U.S.A                    |                                          | VIDOWE   |                                 | Allegan                     | ,            |                      | MD.                               |
|               | ITY OR TOWN OF DEATH                                       |                          | HOSPITAL, NURSING                        |          | OR OTHER INSTITUTION            | 12a USUAL OCCUPATION        | N            |                      | OF BUSINESS OR                    |
| L             | uke                                                        |                          | Pratt Stree                              |          |                                 | Administra                  |              | Pane                 | r Co                              |
| USU<br>13a    | IAL RESIDENCE (IF NURSING HOME<br>STATE 136 CO             | OR OTHER INSTITUTION     |                                          |          | 13d. INSIDE CITY LIMITS?        | 13e STREET ADDRESS          | -            | - i upic             |                                   |
|               |                                                            | egany                    | Luke                                     |          | YES X NO                        | 411 Praz                    | tt S:        | troot 2              | 1540                              |
| _             | ATHER'S NAME                                               | MIDDLE                   | LAST                                     |          | 15. MOTHER'S MAIDEN NAM         | ME                          |              |                      |                                   |
|               | Marcus                                                     | Anderson                 |                                          |          | Jessie                          | MODLE                       | (            | Grauson              | 51                                |
|               | WAS DECEASED EVER IN U.S. A                                | ARMED FORCES?            | 166 SOCIAL SECURIT                       | Y NO.    | 17 INFORMANT                    | ADDRE                       | SS           |                      |                                   |
|               | yes w                                                      |                          | 216-07-93                                | 359      | Beverly R. Jo                   | ickson 115 wa               | TSOV         | r St. I no           | masville                          |
|               | 18 CAUSE OF DEATH (Enter                                   |                          | lige Joyfa), (b), and (c                 | (1.)     | 14                              | 110 60.                     | 7911         | APPROX<br>BETWEEN    | IMATE INTERVAL<br>ONSET AND DEATH |
|               | PART I. DEATH WAS CAU                                      | SED BY:<br>ATE CAUSE (0) | Chronic                                  | - 01     | ashrulat                        | Whent                       | he           | -6                   | plan                              |
|               |                                                            | DUE TO, O                | R AS A CONSEQUENC                        | CEOF     |                                 |                             | 200          |                      |                                   |
|               | Canditians, if any, which                                  | ( (b)_                   |                                          |          |                                 |                             |              |                      |                                   |
|               | gave rise to immediate cause (a), stating the              | DUE TO, O                | R AS A CONSEQUENCE                       | CE OF    |                                 |                             |              |                      |                                   |
| 1             | underlying couse lost.                                     | ( tc)_                   |                                          |          |                                 |                             |              |                      |                                   |
| ,             | PART 2. OTHER SIGNIFICAN                                   | CONDITIONS CO            | ONTRIBUTING TO DEA                       | ATH BUT  | NOT RELATED TO THE TERM         | INAL DISEASE OR COND        | ITION C      | GIVEN IN PART 1      | 01                                |
| CERTIFICATION |                                                            |                          |                                          |          |                                 |                             |              |                      |                                   |
| Š             | 190. DATE OF OPERATION                                     | 196. COND                | ITION FOR WHICH OF                       | PERATIO  | N WAS PERFORMED                 | 20a AUTOPSY?                | IN CER       | YES, WERE FINDI      | NGS USED<br>OF DEATH?             |
| E             |                                                            |                          | 5 9 10 10 1                              |          | Val. How him a com-             | YES NO M                    |              | YES                  | NO 🔀                              |
|               | 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF E    |                          | M. MONTH DAY                             | YEAR     | 21c. HOW INJURY OCCURR          | (ED (ENTER NATURE OF INJUR  | r IN ITEM 11 | B, PART 1 OR PART 2) |                                   |
| MEDICAL       | (IF EITHER, NOTIFY MEDICAL EXAMIN                          | ER] P.                   | M.                                       | 19       | AM LOCATION                     |                             |              |                      |                                   |
| MED           | 21d. INJURY OCCURRED  WHILE   NOT WHILE                    |                          | OF INJURY<br>REET, FACTORY, OFFICE, FARM | A, ETC.) | 21f. LOCATION<br>STREET         | CITY OR TOW                 | N            | COUNTY               | STATE                             |
| 13            | AT WORK                                                    |                          |                                          | -        | 197                             | Pal                         | -            | 0.                   |                                   |
|               | 22a.1 certify that (1) (this has<br>saw the deceased alive | 10 11                    | deceased from 19 8                       | -        | nd that in (my) (our) opinion o | enth occurred on the do     | te and h     |                      | that (I) (we) last                |
|               | obg (1) (we) (did) (did                                    |                          | dter death.                              |          | DEGREE                          | scam accorded an me da      | ic ond in    | 22c DATE             |                                   |
|               | 1011.4                                                     | Kan                      | 1 M.                                     | 1        | ATTENDING                       | MEDICAL STAF                |              | 12/1                 | 0/8.                              |
| 1             | 226 PHYSICIAN'S NAME (TYPE                                 | ORPRINTI                 | A I'M                                    | N        | PHYSICIAN 2                     | DIRECTOR   PHYSIC           | AN           | 14/1                 | 103                               |
|               | Dr. Robert (                                               | 1. ROSA                  | Th MD                                    |          | Ashbiold Stu                    | not Diodmo                  | un +         | (1) 11 = 0           | 67 E A                            |
| 730           | BURIAL, CREMATION, REMOVA                                  |                          |                                          | MEGEC    | Ashfield Str                    |                             | m,           | w.va. 2              | 0/30                              |
|               | (SPECIFY)                                                  |                          |                                          |          |                                 | CITY OR TOWN                | a. ale       | COUNTY               | STATE                             |
|               | UNERAL DIRECTOR                                            | Dec. 20                  | 14821 PM                                 | uco.     | s Cemetery                      | Westernoo                   |              |                      | Maryland<br>TURE                  |
|               | Fredloch Funero                                            | Il Home                  | Diodmont                                 | 01 1/2   |                                 | DEC 23 198                  |              | Mis waydo            | m-Handa De                        |

Frédlock Funeral Home, Piedmont, W.Va. 26750

DHMH-16 60M 1/73 (VR A 15 (4))

IMPORTANT: If hem 21 is marked an Item 18 shd

AND THE PROPERTY OF THE PROPER

tilitari 1981. Therefore a land to the King Taylor and the August a

La constant a constant de la constan

THE RESERVE OF THE PROPERTY OF

|                                                                                                                                             | EOD                                                                                                                     | F THE HILLS                                                                     | STATE OF MARYLAND TMENT OF HEALTH AND MENTAL H | VOIENE 8 5                                                    | 3 2 3 5 7                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|------------------------------------------------|---------------------------------------------------------------|-----------------------------------------------------------------------|
| 365070                                                                                                                                      | REGISTRAR LAVALE,                                                                                                       | TONAL HWY MD 21502                                                              | CERTIFICATE OF DEATH                           | REG. NO.                                                      |                                                                       |
| - 1L                                                                                                                                        | f. DECEASED NAME FIRST                                                                                                  | MIDDLE                                                                          | tAST                                           | 20. DATE OF DEATH MONTH                                       | DAY YEAR 26 HOUR                                                      |
| poge 3                                                                                                                                      | JOHN                                                                                                                    | THOMAS                                                                          | POLAND                                         | DECEMBER 24,                                                  | 1985 M                                                                |
| moy pog                                                                                                                                     | 3. SEX                                                                                                                  | 4 RACE                                                                          | 5. DATE OF BIRTH MONTH DAY YEAR                | & AGE (IN YEARS LAST BIRTHDAY)                                | F UNDER TYEAR F UNDER 24 HRS                                          |
| oge 4 mo<br>ector, po<br>urs ofter                                                                                                          | Male                                                                                                                    | White                                                                           | Nov. 8, 1903                                   |                                                               | RS                                                                    |
| eoth. Po                                                                                                                                    | To BIRTHPLACE (STATE OR FOREIGN Maryland                                                                                | TE CITIZEN OF WHAT COUNTRY  USA                                                 | MARRIED NEVER MARRIED WIDOWED DIVORCED         |                                                               |                                                                       |
| Softer Softer                                                                                                                               | Cumberland                                                                                                              | 11. NAME OF HOSPITAL, NURS (IF NOT IN SUCH FACILITY, GIVE STRE  SACRED HEART HI |                                                | 120. USTAL OCCUPATION (TYPE OF WORK FOR MOST OF WORK  Retired | 176. KIND OF BUSINESS OR INDUSTRY  Textile                            |
| filled in ould be                                                                                                                           | 13a. STATE 13b. CC                                                                                                      | or other institution, give residence Berounty  legany lac. CITY OR TO           | WN 134. INSIDE CITY LIMITS                     | 13. STREET ADDRESS / ZIP (12810 Knobl                         | code 21502<br>ey View Dr.                                             |
| mpletely and 2 sh                                                                                                                           | 14. FATHER'S NAME FIRST Howard                                                                                          | MDDLE Polance                                                                   | 15. MOTHER'S MAIDEN                            | Minerva                                                       | Allen                                                                 |
| 5 9- 62                                                                                                                                     | 160 WAS DECEASED EVER IN U.S.                                                                                           | ARMED FORCES? 166. SOCIAL SEC                                                   |                                                | ADDRESS                                                       | ALLEH                                                                 |
| ficate be exect<br>physician and or<br>popers. Pages<br>tovol.<br>ent, the medical                                                          | (YES, NO OR UNKNOWN) (IF YES,                                                                                           | GIVE WAR OR DATES) 217 10                                                       | Vallie V.                                      | Poland - sam                                                  | e as above                                                            |
| quires that the death certilisided by the attending proper remove carbon to burial, cremotion, or remainiury, or other troumatic eventions. | Conditions, if ony, which gove rise to immediate cause Io1, stating the underlying cause lost.  PART 2 OTHER SIGNIFICAN |                                                                                 | UENCE OF  DEATH BUT NOT RELATED TO THE TE      |                                                               |                                                                       |
| N. The low re hysicion. reost permit. Hygicappier prior 188 shows ony it.                                                                   | 190 DATE OF OPERATION  210. ACCIDENT WAS UNDERLYING                                                                     | 196 CONDITION FOR WHIC                                                          | CH OPERATION WAS PERFORMED                     |                                                               | IF YES, WERE FINDINGS USED<br>ERTIFYING CAUSES OF DEATH?<br>YES NO NO |
| SIC1A<br>ng pl<br>certif<br>uriol-t<br>entol                                                                                                | OR CONTRIBUTING CAUSE OF                                                                                                | DEATH HOUR A.M. MONTH P.M.                                                      | DAY YEAR<br>19                                 | URRED (ENTER NATURE OF INJURY IN ITE                          | M 18 PART I ORPART ?)                                                 |
| DING PHY<br>or ottendi<br>After this<br>se as the bu                                                                                        | 214 INJURY OCCURRED  WHITE NOT WHITE AT WORK                                                                            | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE                       |                                                | CITY OR TOWN                                                  | COUNTY STATE                                                          |
| ATTEN<br>Sspitol<br>ECTOR:<br>d for us<br>m 21 is                                                                                           |                                                                                                                         | on                                                                              | A. (A                                          | on death occurred on the date on                              | , iv, mar (i) (we) tosi                                               |
| HOSPITAL OR Index by the high by the high be deteched in the State Depth ORTANT: If the                                                     | 274 PHYSICIAN'S NAME (IV                                                                                                | pe or prints                                                                    | ATTENDING<br>PHYSICIAN<br>22e ADDRESS          | STAFF DIRECTOR   PHYSICIAN [                                  |                                                                       |
| TO HOSPITAL of retoined by the TO FUNERAL should be detoined with the Store LIMPORTANT. If                                                  | URIEL VELAN                                                                                                             | DIA M.D.                                                                        | 924 SETON                                      |                                                               | AND, MD 21502                                                         |
| BP                                                                                                                                          | 130. BURIAL, CREMATION, REMOVE (SPECIFY) Burial                                                                         | Dec. 28, 1985                                                                   | Hillcrest Buri                                 | al Cumberlan                                                  |                                                                       |
| DHMH - 16 50M 4/83<br>(VRA 15, 4)                                                                                                           | John J. Hafe                                                                                                            | r, Jr. Lavale                                                                   | , MD 21502                                     | CTE 27 BY REGISTRAR 256 RI                                    | GISTRARSSIGNATURE                                                     |

CELLIDE. England B. voli THE PROPERTY OF THE PARTY OF TH Transport descriptions of present and many TO Year Velocul 1:00 237 10 4067 Vollig V. Pollend - come on above UPSET VALUE VALUE OF STREET DELVE CONSESSION, 190 21502 Donglas . Cor. 199 Hillorest Parlel Comberlend, Alleg. . St. John J. Maron, John Layele, MD 27502 Trans

| 008086                                                                                                                                                                                                                   |                 | FOR<br>STATE<br>REGISTRAR                                                             |                        |                                                                  |                                  | ARTMENT OF H<br>CERTIF      | E OF MARYLANI<br>EALTH AND ME<br>ICATE OF DE | NTAL HYG             | REG. NO.                                                         | 3                | 2                             | 60                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|---------------------------------------------------------------------------------------|------------------------|------------------------------------------------------------------|----------------------------------|-----------------------------|----------------------------------------------|----------------------|------------------------------------------------------------------|------------------|-------------------------------|---------------------------------------------------|
| may be<br>page 3<br>ter death                                                                                                                                                                                            | 1. DEC<br>(TIME | CASED NAME RU                                                                         | FIRST                  | 4. RACE                                                          | B                                | S. DATE C                   |                                              |                      | 20. DATE OF DEATH MODELE PROPERTY OF A SEE (IN YEARS LAST BIRTHO | 28<br>(AY)       | 1985 FUNDER I YEAR ONTHS DAYS | 2b. HOUR  24 30 A. M  IF UNDER 24 HRS  HOURS MIN. |
| A section                                                                                                                                                                                                                | 1               | female                                                                                |                        | white                                                            |                                  | MONTH                       | 1-28-190                                     | 18                   | 77                                                               | YRS              | DAYS DAYS                     | HOURS MIN.                                        |
| 0 1 1 25                                                                                                                                                                                                                 |                 | NTHPLACE ISTATE DRIFT ON HO                                                           | REGN                   | 76. CITIZEN OF                                                   | A                                | MARRIE                      | D NEVER MAI                                  | RCED [               | P BALTIMORE CITY OR C<br>Allegany                                | COUNTY           | OF DEATH                      | MD.                                               |
| 10                                                                                                                                                                                                                       | 1112            | wortown of DEAT<br>umberland                                                          | H                      | NURS NO                                                          | HOSPITAL, NUTHER FACILITY, GIVES | IRSING HOME (IREET ADDRESS) | OROTHER INSTITUTION BERL                     | TER                  | 12d. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF W  housewife     |                  | INDUSTRY                      | home                                              |
| filled in multiple for                                                                                                                                                                                                   |                 | PA                                                                                    | THE COUN               | OTHER INSTITUTION                                                | GIVE RESIDENCE E                 | BEFORE ADMISSION)           | 13d. INSIDE CITY                             |                      | 13e. STREET ADDRESS BOX                                          | x 325            | /                             | 19999                                             |
| MARYLAND  Bid within 24  ompletely fillia  and 2 should                                                                                                                                                                  | М. FA           | THER'S NAME FIRST MOTTIS                                                              |                        | MIDDLE                                                           | LAST                             |                             | 15. MOTHER'S M                               | ST                   | e Weiner                                                         |                  | LAS                           | ST                                                |
| BALTIMORE,<br>to be execu-<br>topers, Fage-<br>to the medical                                                                                                                                                            |                 | VAS DECEASED EVER II                                                                  |                        | MED FORCES?<br>E WAR OR DATES)                                   |                                  | SECURITY NO.<br>2-0959      | Mrs. E.                                      |                      | address<br>eth Weisman-C                                         |                  | ville,                        | PA-siste:                                         |
| as that disoth of the by the other fraumatic even                                                                                                                                                                        | CATION          | Conditions, if any, gove rise to imm cause (a), stoting underlying couse              | which ediote the lost. | D BY: E CAUSE (a)  DUE TO, O  (b)  DUE TO, O  (c)  CONDITIONS CO | R AS A CONSI                     | EQUENCE OF                  | Z.,                                          |                      | inal disease or condit                                           |                  | N IN PART 10                  |                                                   |
| DIVISION OF VITAL RECORDS, ING PHYSICIAN The fow require carefuling physician. When this certificate has been sign on the burnel thygene prior to be the and Mental thygene prior to backed or term 18 shows any injury. | AL CERTIFICA    | 190 DATE OF OPERAT                                                                    | RLYING C               | ] 21b. TIME O<br>HOUR A.                                         | F INJURY<br>M. MONTH             | DAY YEAR                    | 21c. HOW INJU                                |                      |                                                                  | N CERTIFY<br>YES |                               |                                                   |
| NG PHYSIC<br>otherding<br>the that cer<br>on the burn<br>th and Ment                                                                                                                                                     | MEDIC           | (IF EITHER NOTIFY MEDIC.  21d. INJURY OCCURRI                                         | D                      | 21e PLACE                                                        |                                  | FICE, FARM, ETC.)           | 21f LOCATION<br>STREET                       | 12.0                 | CITY OR TOWN                                                     | 2                | COUNTY                        | STATE                                             |
| ATTENDE<br>emphal or<br>ECTOR, A<br>ad for one<br>it, of Heali<br>in 21 is mu                                                                                                                                            |                 | 22a.1 certify that (1) (<br>saw the deceased<br>abave, (1) (we) (di<br>22b. SIGNATURE | d alive an             | 12/                                                              | 26                               | 19 \$ 7,00                  | nd that in (my) (au                          | or) apinion o        | death occurred an the date                                       | and haur         | and fram the                  |                                                   |
| PITAL OR<br>by the by<br>ERAL DIR<br>State Day<br>AMT. If the                                                                                                                                                            |                 | 22d. PHYSICIAN'S NA                                                                   | WE (TYPE C             | all<br>R PAINT)                                                  | w                                | /                           | M ATT                                        | ENDING<br>YSICIAN [] | MEDICAL STAFF                                                    | N D              | 11/8                          | 28/85                                             |
| TO HOS should should IMPOR!                                                                                                                                                                                              | 23a. B          | URIAL, CREMATION, F                                                                   | A                      | 123b. DATE                                                       | S                                | MV) 23c. NAME OF C          | EMETERY OR CRE                               | MATORY               | Stalles<br>123d LOCATION                                         | th.              | lim                           | bellens                                           |
| 144BP49                                                                                                                                                                                                                  | (               | Burial                                                                                |                        | 12-31-                                                           |                                  |                             | on Natl'                                     |                      | Arlingto                                                         | on P             | rlingt                        | ton VA                                            |
| DHMH - 16 50M 4/B2<br>(VRA 15, 4)                                                                                                                                                                                        | 24 FL           | James F. S                                                                            | carp                   | elli, C                                                          | umberla                          | and, MD                     | 21502                                        | JAN                  | C'D. WES                                                         | arship           | an Alan                       | ALCON IN                                          |

1 - 51-1985 HILLINGUM NO 11 CP.

V. A. Ranjithan, M. D.

12/31/85

230. BURIAL, CREMATION, REMOVAL

Burial

(SPECIFY)

24 FUNERAL DIRECTOR

STATE OF MARYLAND

2b. HOUR

12h KIND OF BUSINESS OR

Rossworm

BETWEEN ONSET AND DEATH

21502

10:45

IF UNDER 24 HRS

85

IF UNDER 1 YEAR

INDUSTRY

COUNTY

22c DATE SIGNED

Allegany

2-30-51

STATE

MD

BP. DHMH - 16 60M 7/84 (VRA 15, 4)

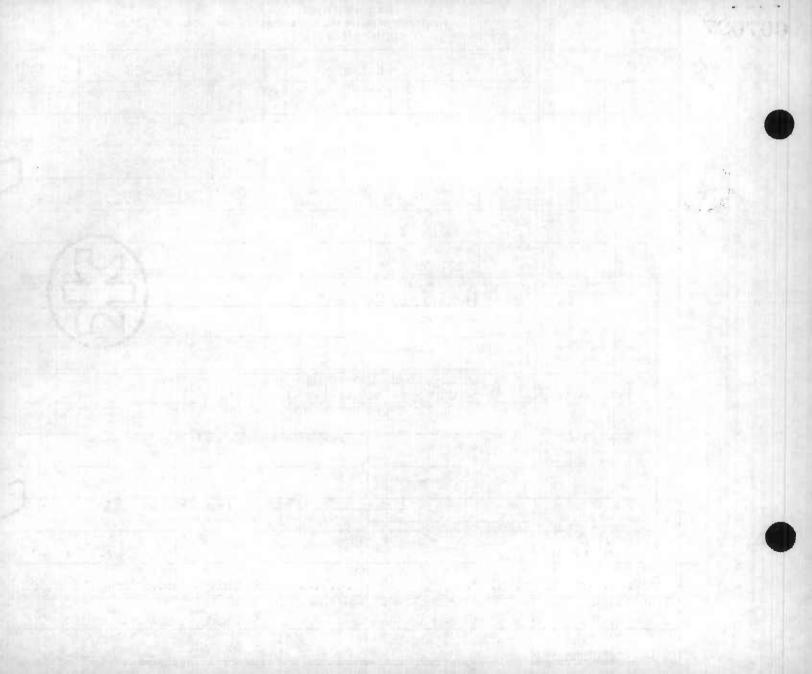
Leasure-Stein Funeral Home, Int Date REC'D. BY REGISTRAR 256. REGISTRAR'S SIGNATURE 230 Baltimore Ave. Cumberland, MD 21502

23c. NAME OF CEMETERY OR CREMATORY

SS Peter & Paul

L.M.N.H. Seton Drive, Cumberland, MD 21502

Cumberland



FOR

010122

poge 3

an and completely filled in by the fune of units. Pages 1 and 2 should be filed within

medical

TO FUNERAL DIRECTOR: After this certificate has been signed by the oriental should be detached for use as the buriol-transit permit. Then places remoi cartia with the State Dept. of Health and Mental Hygiene prior to buriol, crematen MPORTANI: If them 21 is marked or Item 18 shows any injury, or other traumatic.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| - STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CERTIF                                  | ICATE OF DEATH                                                                                                                                                           | REC                                                                                                                     | . NO.                                                                        |                                                                                                   |                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | FIRST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | MIDDLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | " L                                     | AST                                                                                                                                                                      | 20. DATE OF DEAT                                                                                                        |                                                                              | DAY YEAR                                                                                          | 26 HOUR                                                                     |
| TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | SHIRLEY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ANN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | _                                       | RIDGELEY                                                                                                                                                                 | December                                                                                                                |                                                                              | 985                                                                                               | 1:55 N                                                                      |
| SEK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4. RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. DATE C                               |                                                                                                                                                                          | 6 AGE (IN YEARS LAS                                                                                                     | T BIRTHDAY)                                                                  | MONTHS DAYS                                                                                       |                                                                             |
| Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | W}                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | nite                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | May                                     | 25, 1941                                                                                                                                                                 | 44                                                                                                                      | YRS.                                                                         |                                                                                                   |                                                                             |
| BIRTHPLACE (STATE OR FOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | IGN 76 CITIZEN OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | WHAT COUNTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 7? 8<br>MARRIE                          | D X NEVER MARRIED                                                                                                                                                        |                                                                                                                         |                                                                              | TY OF DEATH                                                                                       |                                                                             |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | U.S.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | WIDOWE                                  |                                                                                                                                                                          |                                                                                                                         |                                                                              |                                                                                                   | MD                                                                          |
| CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | HOSPITAL, NURS<br>CH FACILITY, GIVE STREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                         | OR OTHER INSTITUTION                                                                                                                                                     | 12a USUAL OCCUP                                                                                                         |                                                                              |                                                                                                   | OF BUSINESS OR                                                              |
| Cumberland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | morial H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         | 1                                                                                                                                                                        | Housey                                                                                                                  | rife                                                                         |                                                                                                   |                                                                             |
| SUAL RESIDENCE (IF NURSING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | HOME OR OTHER INSTITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 13c. CITY OR TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         | 13d. INSIDE CITY LIMITS?                                                                                                                                                 | 13e STREET ADDRE                                                                                                        | SS / ZIP COI                                                                 | DE                                                                                                |                                                                             |
| aryland A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Allegany                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Cumber                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                         | YES NO                                                                                                                                                                   | 225 Oak                                                                                                                 |                                                                              |                                                                                                   | 21502                                                                       |
| FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | MIDDLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | LAST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                         | 15 MOTHER'S MAIDEN N                                                                                                                                                     | IAME                                                                                                                    |                                                                              |                                                                                                   |                                                                             |
| Patrick                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | O.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Mve                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | re                                      | Marcar                                                                                                                                                                   |                                                                                                                         | .t                                                                           |                                                                                                   | arod.                                                                       |
| WAS DECEASED EVER IN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | U.S. ARMED FORCES?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 166 SOCIAL SEC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                         | Margar<br>17 INFORMANT                                                                                                                                                   | AD                                                                                                                      | DRESS                                                                        | Call                                                                                              | 11.00                                                                       |
| (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 220-38-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 0221                                    | Merritt A                                                                                                                                                                | Ridgele                                                                                                                 | V                                                                            | same a                                                                                            | as 13a-                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Enter only one couse pe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | r line for (a), (b), a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | and (2)                                 | 0 0                                                                                                                                                                      | 0-4                                                                                                                     |                                                                              |                                                                                                   | XIMATE INTERVAL                                                             |
| 18 CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | CALIFED DV                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1/2                                     | - / - //                                                                                                                                                                 | 11:11                                                                                                                   | -1                                                                           |                                                                                                   | mark                                                                        |
| 18 CAUSE OF DEATH<br>PART I. DEATH WAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 0011                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Xan                                     | en enes                                                                                                                                                                  | and all                                                                                                                 |                                                                              |                                                                                                   |                                                                             |
| PART I. DEATH WAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | MEDIATE CAUSE (a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | pac                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Xon                                     | ear endo                                                                                                                                                                 | again                                                                                                                   |                                                                              | , 2                                                                                               | 7719110                                                                     |
| PART I. DEATH WAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | DUE TO, C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | OR AS A CONSEQU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | UENCE OF                                | earendo                                                                                                                                                                  | man                                                                                                                     |                                                                              |                                                                                                   | 7719010                                                                     |
| PART I. DEATH WAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | DUE TO, O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | DR AS A CONSEQU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | UENCE OF                                | es indo                                                                                                                                                                  | an great                                                                                                                | <u> </u>                                                                     | /                                                                                                 | 2719070                                                                     |
| Conditions, if ony, y gove rise to immediate to its stating                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | DUE TO, C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | DR AS A CONSEQUENCE OF A CONSEQU |                                         | en endo                                                                                                                                                                  | anguu.                                                                                                                  |                                                                              |                                                                                                   | 2714110                                                                     |
| Conditions, if ony, v gove rise to immed couse (a), stating                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | DUE TO, C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         | eg endo                                                                                                                                                                  | a gove                                                                                                                  |                                                                              | ,                                                                                                 | 7719,112                                                                    |
| Conditions, if ony, v<br>gove rise to imme-<br>cause (a), stating<br>underlying cause                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | DUE TO, C  vhich diate the lost. (c)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | DR AS A CONSEQU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | UENCE OF                                | NOTELAND TO THE                                                                                                                                                          | RMINAL DISEASE OR C                                                                                                     | ONDITION G                                                                   | SIVEN IN PART I                                                                                   | No.                                                                         |
| Conditions, if ony, v<br>gove rise to imme-<br>cause (a), stating<br>underlying cause                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | DUE TO, C  vhich diate the lost. (c)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | DR AS A CONSEQU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | UENCE OF                                | NOTABLAND TO THE TE                                                                                                                                                      | RMINAL DISEASE OR C                                                                                                     | ONDITION G                                                                   | GIVEN IN PART 1                                                                                   | to                                                                          |
| Conditions, if only, v<br>gove rise to immer<br>couse (a), stating<br>underlying couse                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | DUE TO, O  which diate the DUE TO, O  LICANT COMBITIONS A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | OR AS A CONSEQUE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | UENCE OF                                | NOTAETAND TO THE LET                                                                                                                                                     | RMINAL DISEASE OR C                                                                                                     | 20b. 1F Y                                                                    | ES, WERE FIND                                                                                     | INGS USED                                                                   |
| Conditions, if ony, v<br>gove rise to imme-<br>cause (a), stating<br>underlying cause                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | DUE TO, O  which diate the DUE TO, O  LICANT COMBITIONS A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | OR AS A CONSEQUE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | UENCE OF                                | elitu                                                                                                                                                                    | 200 AUTOPSY?                                                                                                            | 20b. IF Y                                                                    | ES, WERE FIND                                                                                     | INGS USED<br>S OF DEATH?                                                    |
| Conditions, if only, v<br>gove rise to immer<br>cause (a), stating<br>underlying cause                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | DUE TO, O  which (b) the DUE TO, O  clost. (c) CCANT COMBITIONS  19b. COND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | OR AS A CONSEQUENCE ON TRIBUTING TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | DEATH BUT                               | MAS PERFORMED LUS                                                                                                                                                        | 20a AUTOPSY? YES NO[                                                                                                    | 20b. IF Y                                                                    | ES, WERE FIND<br>TIFYING CAUSE<br>YES                                                             | INGS USED                                                                   |
| PART I. DEATH WAS IM  Conditions, if ony, v gove rise to immer cause (a), stating underlying cause  PART 2 OTHER SIGNIF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | DUE TO, O  which diote the DUE TO, O  lost. (c)  CICANT COMBITIONS O  LYING   19b. COND  LYING   21b. TIME C  HOUR A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | OR AS A CONSEQUENCE ON TRIBUTING TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | DEATH BUT                               | elitu                                                                                                                                                                    | 20a AUTOPSY? YES NO[                                                                                                    | 20b. IF Y                                                                    | ES, WERE FIND<br>TIFYING CAUSE<br>YES                                                             | INGS USED<br>S OF DEATH?                                                    |
| PART I. DEATH WAS  IM  Conditions, if ony, v gove rise to immer couse (a), storing underlying couse  PART 2 OTHER SIGNIF  21a, ACCIDENT WAS UNDER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | DUE TO, O  which diote the DUE TO, O  lost. (c)  CICANT COMBITIONS  DN 19b. COND  LYING 12b. TIME C  HOUR A  EXAMINER) P                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | OR AS A CONSEQUENCE ON TRIBUTING TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | DEATH BUT                               | N MAS PERFORMED                                                                                                                                                          | 20a AUTOPSY? YES NO[                                                                                                    | 20b. IF Y                                                                    | ES, WERE FIND<br>TIFYING CAUSE<br>YES                                                             | INGS USED<br>S OF DEATH?                                                    |
| PART I. DEATH WAS  IM  Conditions, if ony, v gove rise to imme- couse (a), stating underlying cause  PART 2 OTHER SIGNIF  19a DATE OF OPERATIC  21a, ACCIDENT WAS UNDER OR CONTRIBUTING CAL (IF EITHER NOTIFY MEDICAL  21d INJURY OCCURRET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | DUE TO, O  which diote the DUE TO, O  lost. (c)  FICANT COMBITIONS A  LYING   19b. COND  LYING   21b. TIME C  HOUR A  EXAMINER)   P  21e. PLACE  (a1 HOME ST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | OR AS A CONSEQUENCE ON TRIBUTING TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | DEATH BUT<br>HOPERATIO<br>DAY YEAR      | MAS PERFORMED LUS                                                                                                                                                        | 200 AUTOPSY?  YES NO [  URRED (ENTER NATURE OF                                                                          | 20b. IF Y                                                                    | ES, WERE FIND<br>TIFYING CAUSE<br>YES                                                             | INGS USED<br>S OF DEATH?                                                    |
| PART I. DEATH WAS IM  Conditions, if ony, v gove rise to immer couse (a), storing underlying couse  PART 2 OTHER SIGNIF  19a DATE OF OPERATION 21a, ACCIDENT WAS UNDER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | DUE TO, O  which diote the DUE TO, O  lost. (c)  FICANT COMBITIONS A  LYING   19b. COND  LYING   21b. TIME C  HOUR A  EXAMINER)   P  21e. PLACE  (a1 HOME ST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ONTRIBUTING TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | DEATH BUT<br>HOPERATIO<br>DAY YEAR      | TIL HOW INJURY OCCU                                                                                                                                                      | 200 AUTOPSY?  YES NO [  URRED (ENTER NATURE OF                                                                          | 20b. IF Y<br>IN CERT                                                         | YES, WERE FIND<br>TIFYING CAUSE<br>YES<br>YES PART 1 OR PART 2)                                   | INGS USED<br>S OF DEATH?<br>NO                                              |
| PART I. DEATH WAS  IM  Conditions, if ony, v gove rise to immer couse toi, storing underlying couse  PART 2 OTHER SIGNIF  21a. ACCIDENT WAS UNDER OR CONTRIBUTING  CIFETTHER NOTIFY MEDICAL  21d. INJURY OCCURREI  AT WORK  NOTE WHILE AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | DUE TO, O  which diote the DUE TO, O  lost. (c)  FICANT COMBITIONS A  LYING   19b. COND  LYING   21b. TIME C  HOUR A  EXAMINER)   P  21e. PLACE  (a1 HOME ST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | OR AS A CONSEQUENCE ON TRIBUTING TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | DEATH BUT  OPERATO  DAY YEAR  19        | TIL HOW INJURY OCCU                                                                                                                                                      | 200 AUTOPSY?  YES NO [  URRED (ENTER NATURE OF                                                                          | 20b. IF Y<br>IN CERT                                                         | YES, WERE FIND<br>TIFYING CAUSE<br>YES<br>YES PART 1 OR PART 2)                                   | INGS USED<br>S OF DEATH?<br>NO                                              |
| PART I. DEATH WAS  Conditions, if ony, v gove rise to immer cause 10, storing underlying cause  PART 2 OTHER SIGNIF  19a DATE OF ORERATIC  21a. ACCIDENT WAS UNDER OR CONTRIBUTING   CAL (IF EITHER NOTIFY MEDICAL 21d INJURY OCCURREL)  WHILE   NOT WHILE AT WORK   AT WORK  22a.l certify that (II)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | DUE TO, O  which (b) diate the DUE TO, O  lost. (c)  PICANT CONDITIONS  LYING   19b. COND  LYING   21b. TIME O  HOUR A  EXAMINER)   P  21e. PLACE (AT HOME ST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | OR AS A CONSEQUENCE OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | DAY YEAR  19 E, FARM, ETC.)             | 211 LOCATION<br>STREET                                                                                                                                                   | 200 AUTOPSY? YES NO DIRRED (ENTER NATURE OF                                                                             | 20b. IF Y IN CERT                                                            | COUNTY                                                                                            | INGS USED S OF DEATH? NO STATE                                              |
| PART I. DEATH WAS  Conditions, if ony, v gove rise to immer couse (o), storing underlying couse  PART 2 OTHER SIGNIF  21a. ACCIDENT WAS UNDER OR CONTRIBUTING   CAL (IF EITHER NOTIFY MEDICAL 21a. IN JURY OCCURREL  WHILE   NOT WHILE AT WORK   NOT W | DUE TO, O  which (b) diate the lost. (c) EICANT COMBITIONS.  LYING   21b. TIME C HOUR A EXAMINER)  21e. PLACE (AT HOME ST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | OR AS A CONSEQUENCE OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | DEATH BUT  DAY YEAR  19  E, FARM, ETC.) | 211 LOCATION<br>STREET                                                                                                                                                   | 200 AUTOPSY? YES NO DIRRED (ENTER NATURE OF                                                                             | 20b. IF Y IN CERT                                                            | COUNTY                                                                                            | INGS USED S OF DEATH? NO STATE                                              |
| PART I. DEATH WAS  IM  Conditions, if ony, v gove rise to immer cause (a), stotning underlying cause  PART 2 OTHER SIGNIF  21a, ACCIDENT WAS UNDER  21a, ACCIDENT WAS UNDER COR CONTRIBUTING CAL (IF EITHER NOTIFY MEDICAL  21d INJURY OCCURRE!  WHILE AT WORK  22a. I certify that (1)  sow the deceased above (1) (we) (due)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | DUE TO, O  which (b) diate the DUE TO, O  lost. (c)  PICANT CONDITIONS  LYING   19b. COND  LYING   21b. TIME O  HOUR A  EXAMINER)   P  21e. PLACE (AT HOME ST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | OR AS A CONSEQUENCE OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | DEATH BUT  DAY YEAR  19  E, FARM, ETC.) | 211 LOCATION STREET  19 and that IV (my Lour) aprince                                                                                                                    | 200 AUTOPSY? YES NO [  JRRED (ENTER NATURE OF  CITY C  10 3/  11 death accurred on the                                  | 20b. IF Y IN CERT                                                            | COUNTY                                                                                            | INGS USED S OF DEATH? NO  STATE , that (we) last                            |
| PART I. DEATH WAS  IM  Conditions, if ony, v gove rise to imme- cause (a), stating underlying cause  PART 2 OTHER SIGNIF  21a. ACCIDENT WAS UNDER OR CONTRIBUTING CAU (IF EITHER NOTIFY MEDICAL AT WORK  22a. I certify that (1)) Sow the deceased above (1) (we) (did                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | DUE TO, O  which diate the DUE TO, O  lost. (c)  FICANT COMBITIONS O  LYING   19b. COND  LYING   21b. TIME C  HOUR A  EXAMINER)   P  21e. PLACE  (AT HOME ST  And I shappital) attended the olive an and other standard sta | OR AS A CONSEQUENCE OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | DEATH BUT  DAY YEAR  19  E, FARM, ETC.) | 216. HOW INJURY OCCU                                                                                                                                                     | 200 AUTOPSY? YES NO DIRRED (ENTER NATURE OF                                                                             | 20b. IF Y IN CERT                                                            | COUNTY                                                                                            | INGS USED S OF DEATH? NO  STATE , that (we) last                            |
| PART I. DEATH WAS  IM  Conditions, if ony, v gove rise to imme- cause (a), stating underlying cause  PART 2 OTHER SIGNIF  21a, ACCIDENT WAS UNDER OR CONTRIBUTING CAL (IF EITHER NOTIFY MEDICAL 21d IN JURY OCCURREI AT WORK AT WORK 22a. I certify that (II) saw the deceased above (I) (we) (did                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | DUE TO, O  which (b)  diate the DUE TO, O  lost. (c)  FICANT COMBITIONS (c)  PICANT COMBITI | OR AS A CONSEQUENCE ON TRIBUTING TO ONTRIBUTING TO OTHER TRIBUTING TO  | DEATH BUT  DAY YEAR  19  E, FARM, ETC.) | 211 LOCATION STREET  19 ATTENDINGS PHYSICIAN 27e ADDRESS                                                                                                                 | 200 AUTOPSY?  YES NO [  JIRRED (ENTER NATURE OF  CITY OF  MEDICAL   PH                                                  | 20b. IF Y IN CERT                                                            | COUNTY  COUNTY  COUNTY  COUNTY  COUNTY  COUNTY  COUNTY                                            | INGS USED S OF DEATH? NO STATE  that (I) (we) last e causes stated  ESIGNED |
| PART I. DEATH WAS  IM  Conditions, if ony, v gove rise to imme- cause (a), stating underlying cause  PART 2 OTHER SIGNIF  21a, ACCIDENT WAS UNDER OR CONTRIBUTING CAL (IF EITHER NOTIFY MEDICAL 21d IN JURY OCCURREI AT WORK AT WORK 22a. I certify that (II) saw the deceased above (I) (we) (did                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | DUE TO, O  which diate the DUE TO, O  lost. (c)  FICANT COMBITIONS O  LYING   19b. COND  LYING   21b. TIME C  HOUR A  EXAMINER)   P  21e. PLACE  (AT HOME ST  And I shappital) attended the olive an and other standard sta | OR AS A CONSEQUENCE ON TRIBUTING TO ONTRIBUTING TO OTHER TRIBUTING TO  | DEATH BUT  DAY YEAR  19  E, FARM, ETC.) | 216. HOW INJURY OCCU                                                                                                                                                     | 200 AUTOPSY?  YES NO [  JIRRED (ENTER NATURE OF  CITY OF  MEDICAL   PH                                                  | 20b. IF Y IN CERT                                                            | COUNTY  COUNTY  COUNTY  COUNTY  COUNTY  COUNTY  COUNTY                                            | INGS USED S OF DEATH? NO STATE  that (I) (we) last e causes stated  ESIGNED |
| PART I. DEATH WAS  IM  Conditions, if ony, v gove rise to imme- couse (a), stating underlying cause  PART 2 OTHER SIGNIF  21a, ACCIDENT WAS UNDER OR CONTRIBUTING CAL (IF EITHER NOTIFY MEDICAL 21d IN JURY OCCURREI AT WORK AT WORK  22a. I certify that (II) saw the deceased above (I) (we) (did  DT. F.W. M.  B BURIAL, CREMATION, RE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | DUE TO, O  which (b) diate the DUE TO, O lost. (c)  PICANT CONDITIONS  LYING   19b. COND  LYING   21b. TIME O HOUR A EXAMINER)  21e. PLACE (AT HOME ST  which (at HOME ST  lost on the body  iltenberger                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | OR AS A CONSEQUENCE ON TRIBUTING ICO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | DAY YEAR 19 E, FARM, ETC.)              | 211 LOCATION STREET  19 ATTENDINGS PHYSICIAN 27e ADDRESS                                                                                                                 | 20a AUTOPSY? YES NO DIRRED (ENTER NATURE OF  CITY OF  MEDICAL OR DIRECTOR PH  Test. Cum                                 | 20b. IF Y IN CERT                                                            | COUNTY  COUNTY  22c. DAT  Md.                                                                     | STATE  , that (I) (we) last e causes stated  ESIGNED  21502                 |
| PART I. DEATH WAS  IM  Conditions, if ony, v gove rise to immer cause (a), stating underlying cause  PART 2 OTHER SIGNIF  21a. ACCIDENT WAS UNDER  21a. ACCIDENT WAS UNDER 21a. ACCIDENT WAS UNDER 21a. ACCIDENT WAS UNDER  AT WORK AT WORK  22a. I certify that (II) saw the deceased above (I) (we) (did  DT. F.W. M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | DUE TO, O  which (b) diate the DUE TO, O lost. (c)  PICANT COMBITIONS  LYING (D)  LYING  | ONTRIBUTING TO ONTRIBUTING TO ONTRIBUTING TO ONTRIBUTING TO ONTRIBUTING TO OF INJUTY OF INJURY OTHER TO THE THE TO TH | DAY YEAR  19 E. FARM, ETC.)  NAME OF C  | 211 LOCATION STREET  212 LOCATION STREET  213 LOCATION STREET  214 LOCATION STREET  215 LOCATION STREET  216 ADDRESS  127 ADDRESS  128 ADDRESS  129 ADDRESS  120 S. Cent | 200 AUTOPSY?  YES NO [  URRED (ENTER NATURE OF  CITY OF  MEDICAL  OIRECTOR   PH  Tre St. Cum  23d. LOCATION CITY OF TOW | 20b. IF Y IN CERT INJURY IN ITEM 18 IR IOWN  AR IOWN  CATAFF YSICIAN  berlan | COUNTY  TES, WERE FIND TIFYING CAUSE YES  8 PART 1 OR PART 2)  COUNTY  22c. DAT  22c. DAT  COUNTY | STATE  STATE  And (we) lost to course stated  ESIGNED  21502                |

DHMH - 16 60M 7/84 (VRA 15, 4)

BP.

| 3 | 53058                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 11-           | FOR<br>STATE<br>REGISTRAR |                     |               |                    |               | MENT OF                     | HEALTH        |                          | NTAL H        | .43        | -           | REG. N           | 3 2         | 2 3                | Ö                  | J        |
|---|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------------------|---------------------|---------------|--------------------|---------------|-----------------------------|---------------|--------------------------|---------------|------------|-------------|------------------|-------------|--------------------|--------------------|----------|
|   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1. DE         | CEASED NAM                | E FI                | RST           |                    | MIDDLE        |                             |               | LAST                     |               | 2          |             | KNOWN }          |             | DAY                | YEAR 2             | b HOUR   |
|   | 5 40000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (TYF          | PE OR PRINT)              | D/                  | OV            |                    | E-no.         | 0 ma 0 ha                   | D.            | itchie                   | Tr            | 100        | OF          | ESTI-<br>MATED [ | $\Box$ 12   |                    | 455                |          |
| 6 | SE S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 3. SE         | X                         | 14. RACE            | -             | DATE OF BIRTH      | LLG           | eman                        |               | DER I YR.                |               |            | c. DATE     | WAILD E          | MONTH       |                    | 9 85 YEAR 12       | M        |
| 1 | REC PE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |               |                           |                     | M             | ONTH DAY           | YEAR          | LAST BIRTHE                 | MONTH         | S DAYS                   | HOURS         | MIN. P     | RONOUN      |                  | 10          | 0                  |                    | 0:50     |
| - | A YOU TO YOU YOU TO Y!                                                                             | MA            |                           | WHITE               |               |                    | +1            |                             | RS.           | 4,5                      |               |            | DEAD        |                  |             |                    |                    | а. м     |
| 1 | FCESSARY, PLEASE JARGAL DIRECTOR. FOR YOUR FILES. WITHIN 72 HOURS PRESTON STREET,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | FC            | RTHPLACE (S               |                     | /0.           | CITIZEN OF W       |               | IIRY?                       | 8. MARRI      | ED A NEV                 | ER MARRIE     | D []       |             | ORE CITY         | -           |                    | ATH                |          |
|   | AND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |               | ARYLAI                    |                     |               | U.S.               |               |                             | WIDOW         |                          | DIVORCE       |            |             | legany           |             |                    |                    | MD.      |
|   | OCHESTO /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10. C         | ITY OR TOWN               | OF DEATH            | 11.           | NAME OF HOS        |               | RSING HOM<br>TREET ADDRESS) | E, OR OTH     | ER INSTITUT              | ION           | FOR MO     | OST OF WORL | PATION (TY       | PE OF WORK  | 12b. KIND<br>OR II | OF BUST<br>NDUSTRY | NESS     |
|   | THE SERVICE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1             | Cumber                    |                     |               | Memori             |               |                             |               |                          | 7710          | SUI        | P.V.        |                  |             |                    | ANES               | E        |
|   | E SEE SEE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |               | AL RESIDENCE              |                     | HOME OR OTH   | HER INSTITUTION, G |               | OR TOWN                     | ION)          | T3d. INSIDE (II<br>YES X | TY LIMITS?    | 13a STREE  | ET ADDRE    | SS               | 2.3.        | 2                  | 1532               |          |
|   | IF AN              |               | ARYLAI                    |                     | LLEGA         | ANY                | FRO           | STBUR                       | G             | YES X                    | NO 🗆          | 126        | WA          | SHIN             | GTON        | ST.                |                    |          |
|   | A - 1000 W                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | -             | ATHER'S NAM               |                     |               |                    |               |                             |               | 15. MOTHE                | R'S MAIDEN    | NAME       |             |                  |             |                    |                    |          |
| L |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1             | ROY                       |                     | MIL           | DOLE               | RIT           | CHIE                        |               | EÏ                       | EANO          | R          | M           | IDDLE            |             | YAÑ                | TZ                 |          |
|   | - ~ 4 a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 16a. \        | WAS DECEASE               | D EVER IN U.        | S. ARMED      | FORCES?            | 16b. SOC      | IAL SECURI                  | Y NO.         | 17. INFORM               | ANT WA        | SHI        | VGTO        | NADERIS          | s F         | ROST               | BURG               | MD       |
|   | ALTIMA<br>GIVE PA<br>GIVE PA<br>HI FOR<br>HAGES I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (4            | YES                       | OWN) (IF YE         | S, GIVE WAR C | OR DATES)          | 218           | -40-3                       | 145           | MRS                      | ROY           | RIT        | CHT         | E. J             | R . 1       | 26                 |                    | , -      |
|   | NOT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | -             |                           | DE DE ATH (En       | ter only on   | e couse per line   |               |                             |               | 12.0                     | 1102          |            |             |                  | , , ,       |                    | OXIMATE IN         | TERVAL   |
|   | D S S S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |               | PARTIDI                   | FATH WAS C          | ALISED BY.    |                    |               |                             | cotic o       | Coxdi                    | 011000        |            | Diac        | 2220             |             | BETWE              | EN ONSET A         | ND DEATH |
|   | S SECTION S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | 1000                      | IMM                 | NEDIATE CA    | AUSE (o)           |               | SEQUENCE                    |               | Cardi                    | Ovasc         | ular       | DISE        | ease             |             |                    |                    | -        |
|   | <b>★</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |               | Conditio                  | ins, if ony,        | which         | DOL TO, OK         | AS A COL      | SEGOEINCE                   | OF            |                          |               |            |             |                  |             |                    |                    |          |
|   | A STATE OF THE STA             |               | gave r                    | stoting the u       | ediate        | (b)                | 10 1 001      | 10.7.4                      | 1000          |                          |               |            |             |                  |             |                    |                    |          |
|   | A CANA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |               | lying car                 |                     | nder-         | DUE TO, OR         | AS A CON      | ISEOUENCE                   | OF            |                          | 11            |            |             |                  |             |                    |                    |          |
|   | S S S S S S S S S S S S S S S S S S S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |               |                           |                     |               | (c)                |               |                             |               |                          |               |            |             |                  |             |                    |                    |          |
|   | CERTIFICATE SHOULD BE EXECUTE TING THE WORD "PERDING" IN THE CHEE WORD "PERDING" IN 3 SHOULD BE USED AS A BURIA DEPARTMENT OF HEALTH AND I PRIOR TO BURIAL, CREMATION,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | NO            | PART 2 OTHER S            | IGNIFICANT COND     | OITIONS CONTR | RIBUTING TO DEATH  | BUT NOT RELA  | ITEO TO THE TER             | AINAL OISEASI | OR CONDITION             | GIVEN IN PART | T I (a),   |             |                  |             |                    |                    |          |
|   | LINE TENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | CERTIFICATION | 19a. DATE OF              | POPERATION          | 1             | 19b. CONDI         | TION FOR      | WHICH OPE                   | RATIONW       | AS PERFORA               | MED?          |            |             |                  |             | 20 AU              | TOPSY?             |          |
|   | SHOUSE OF SHOUSE             | E             |                           |                     |               | 1 10 14            |               |                             |               |                          |               |            |             |                  |             | YE                 | s 🕱                | NO 🗆     |
|   | S CERTIFICATE SHOU<br>RITING THE WORD.<br>SPEED TO THE CHIEF<br>ET 3 SHOULD BE USE<br>TO PRIOR TO PHOTO PHOT | 7 H           |                           | AL CAUSE W          | AS            | 21b. TIME OF       |               | DAY VEA                     | 21c. HO       | W INJURY                 | OCCURRED      | (ENTER NA  | TURE OF INJ | URY IN ITEM 18   | PART I OR P |                    | 31                 |          |
|   | NO SHIP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1             | UNDERLYING                | G ☐ OR              | E OF DEAT     |                    |               | DAY YEA                     | R             |                          |               |            |             |                  |             |                    |                    |          |
|   | ISH ISH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | MEDICAL       | 21d INTURY                | OCCUPPED            | -             | 21e. PLACE         | OF INJURY     | (AT HOME,                   |               | CATION                   |               |            | -           |                  |             |                    |                    |          |
|   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ×             | AT WORK                   | NOT WHIL<br>AT WORK | E             | STREET, FAC        | TORY, FARM, E | TC.)                        | S             | TREET                    |               |            | CITY OR TOV | WN               | C           | OUNTY              |                    | STATE    |
|   | DIVIS  MEDICAL EXAMINER: THIS CER ECUTE THE CERTIFICATE, WRITIN ECUTE THE CERTIFICATE, WARTIN ECUTE THE CERTIFICATE, WARTIN ECUTE THE STATE DIRECTOR: PAGE 3.5 FUNERAL DIRECTOR: PAGE 3.5 TER DEATH, WITH THE STATE DEF LITINORE, MARYLAND, 21201 PR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |               |                           | ify that I toak     | charge of     | the remains de     | gribed obg    | Ke, held an                 | Autop         | у [Х],                   | Inspection    | □,         | Inquiry     | □. <u> </u>      | nd in my o  | pinion             |                    |          |
|   | A FE REFERENCE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |               | death result              | red from:           | Natural ca    | ouses X            | recipie       | L, 5                        | ion S         | Hamici                   | de L          | Undeter    | mined ma    | inner,           |             |                    |                    |          |
|   | A K K K K K K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1             | ACTUAL /                  | Alla                |               | 1/1                | X.            | 170                         | 11.           | TITLE (SF                |               |            |             |                  |             |                    |                    |          |
| • | AHEAREM'A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4/            | SIGNATURE                 | Yel                 | Llee          | 1/X                | me            | 101                         | -cu           | <u>Assi</u>              | stant         | MEDIC      | AL EXAM     | INER             | DATE        | ED12               | 2-10-              | 85       |
|   | ED A SE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | EXAMINER'S                | NAME                | Danni         | ~ D C~             |               | M D                         |               |                          | יווו די       | lonn       | C+          | Dalte            | - M         | ua o               | 1201               |          |
|   | TO MEI<br>EXECUT<br>PAGE A<br>TO FUR<br>PATER I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |               | (TYPE OR PRI              | NT)                 |               | s F. Sn            | - 17          |                             |               | ADDRESS                  |               |            |             | Balto            | J., M       | iu. 2              | 21201              |          |
|   | B27759                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 23e.B         | URIAL, CREMA              | TION, REMO          | VAL 23b. D    |                    | Part Land     | NAME OF CE                  | METERY O      | RCREMATO                 | RY            | 23d. LOC   | RIOWN       | 4000             |             | UNTY               | STATE              |          |
|   | 07/84 BP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 0             | THE MAN                   | UON                 | 1             | 2/11/8             | 35 8          | MITH                        |               | CRE                      | MATO          | RYS        | MIT         | HBUR             |             |                    | IGTO:              |          |
|   | 25M DHMH - 17                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 24 F          | NAME DIRECT               | CTOR                | nos           | MINIMO             |               | MAIN                        | ST.           | 2                        | So. DATE RE   | EC'D. BY F | REGISTRA    | R 25b REG        | ISTRAR'S    | SIGNATUR           | RE                 |          |
|   | (VR A15 ME (5))                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 5             | OWERS                     | FUNE                | RAL           | HOME               | FROS          | TBURG                       | }             |                          | UEU           | 16         | 2 130       | gulie            | Davido      | and pr             | Marine .           |          |

250035 OFFIRE SALES COMMENTERS

|     | STATE OF MARYLAND            |
|-----|------------------------------|
| FOR | DEPARTMENT OF HEALTH AND MEN |

HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

LAST

ROBINETTE

5. DATE OF BIRTH

REG. NO 20 DATE OF DEATH MONTH 26 HOUR 1:35P DECEMBER 9. 1985 & AGE (IN YEARS LAST BIRTHDAY) IF UNDER I YEAR IF UNDER 24 HRS 80

Female White Oct. TO BIRTHPLACE (STATE OF FOREIGN 76 CITIZEN OF WHAT COUNTRY? COUMD USA

1905 MARRIED NEVER MARRIED

BALTIMORE CITY OR COUNTY OF DEATH Allegany

13e.STREET ADDRESS / ZIP CODE

Mae

10. CITY OR TOWN OF DEATH

- STATE

3 SEX

REGISTRAR

DECEASED NAME

DIVORCED TO WIDOWED NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

126 KIND OF BUSINESS OR LTYPE OF WORK FOR MOST OF WORKING LIFE INDUSTRY Sales Clerk Liquor Store

OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSIONS JSUAL RESIDENCE (IF NURSING 130. STATE Irgany

4 RACE

4 FATHER'S NAME Charles

> Canditions, if ony, which gove rise to immediate couse (o), stoting the

underlying couse

Robinette

15 MOTHER'S MAIDEN NAME Bessie

Fords Crossing 21524 MIDDLE

IAN WAS DECEASED EVER IN U.S. ARMED FORCES? LYES NO OR UNKNOWN

NOT WHILE

sow the deceased alive on\_

22d. PHYSICIAN'S NAME LITYPE OF RINTI

FIRST

FLORENCE

166 SOCIAL SECURITY NO 214-05-6039

Corriganvi

17. INFORMANT Duane Robinette

. Artemas. PA.

No

CUMBERLAND

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and ic PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE to

MEMORIAL HOSPITAL

DUE TO, OR AS A CONSEQUENCES

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 IG 196 CONDITION FOR WHICH OPERATION WAS PERFORMED

CERTIFICATION 190 DATE OF OPERATION MEDICAL 21d. INJURY OCCURRED

210. ACCIDENT WAS UNDERLYING 216. TIME OF INJURY HOUR A.M. MONTH DAY YEAR OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21e PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

NOF 216. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2

20a AUTOPSY?

20b. IF YES, WERE FINDINGS USED

IN CERTIFYING CAUSES OF DEATH?

COUNTY STATE

NO

Kline

APPROXIMATE INTERVAL

22b SIGNATURE

23b. DATE

220.1 certify that (1) (this hospital) attended the deceased from\_

DEGREE

ATTENDING MEDICAL STAFF
PHYSICIAN DIRECTOR PHYSICIAN

MEMORISAL HOSPITAL

22¢ DATE MEDICAL BUILDING

21502

DR. ZAMAN

230 BURIAL, CREMATION, REMOVAL

CUMBERLAND, MARYLAND 23c NAME OF CEMETERY OR CREMATORY

211 LOCATION

23d LOCATION CITY OR TOWN

Cumberland

and that in (my) (our) opinian death occurred an the date and hour and from the causes stated

CITY OR LOWN

STATE

Burial 24 FUNERAL DIRECTOR William G. Kight

(SPECIFY)

Cumberland

DHMH - 16 60M 7/B4 (VRA 15, 4)

remale white Oct. 4, 1905 80

The USA X Allegany

Sales Clark Liquor Store

AD Allegany Corriganville X Fords Crossing 21524

Charles Kominette Bessie Mae Kline

Duane Kominette , Artemas, FA.

Durial Dec. 12, 1985 Millerest Burial Cumberland Allegany AD

William C. Kight Cumberland, AD

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

poge 3

FOR STATE

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

| REG. N      | 10.   |     |      |                |
|-------------|-------|-----|------|----------------|
| TE OF DEATH | MONTH | DAY | YEAR | 26 HOUR<br>3:5 |
| . 1         | 10    | 100 |      | 3:3            |

|               |                        |             |                      |                         |            |                 |                | REG. N                        | Q.            |                   |                                    |
|---------------|------------------------|-------------|----------------------|-------------------------|------------|-----------------|----------------|-------------------------------|---------------|-------------------|------------------------------------|
|               | CEASED NAME            | FIRST       |                      | MIDDLE                  | The second | LAST            |                | 20 DATE OF DEATH              | MONTH         | DAY YEAR          | 3:50                               |
| (7.11         |                        | OHN         | C                    | HARLES                  | RODE       | NHAUSEF         |                | December                      | 19, 1         | 985               | 3:50<br>n.*                        |
| 3. SE         | X                      |             | 4 RACE               |                         | 5. DATE (  |                 |                | 6 AGE (IN YEARS LAST BIR      | THDAY)        | IF UNDER 1 YEAR   | IF UNDER 24 HRS                    |
|               | male                   |             | whi                  | te                      | MONT       | 01-25-19        | 905 YEAR       | 80                            | YRS           | MONTHS DAYS       | HOURS MIN.                         |
|               | IRTHPLACE (STATE OR    | FOREIGN     | 16 CITIZEN OF        | WHAT COUNTRY?           | B.         | D NEVER A       | APPIED [       | 9 BALTIMORE CITY O            | R COUNT       | Y OF DEATH        |                                    |
|               | MD                     | GZ          | US                   | A                       | WIDOW      | _               | ORCED          | Allegany                      |               |                   | ME                                 |
| 10. C         | ITY OR TOWN OF DEA     | ATH         |                      | HOSPITAL, NURSIN        |            | OR OTHER INST   | ITUTION        | 120. USUAL OCCUPATI           |               |                   | OF BUSINESS OR                     |
| C             | umberland              |             |                      | ial Hospi               |            |                 |                | ret shift                     | Supt          | INDUSTRY          | re Co.                             |
| USU.          | AL RESIDENCE (# NURS   | ING HOME OR | OTHER INSTITUTION    | GIVE RESIDENCE BEFORE   | ADMISSION) | A 124 INICIDE C | TVIIMITED      | 12 CTREET ADDRESS             | / 7/D COD     | -                 |                                    |
|               | MD                     | "AII        | egany                | LaVale                  | N          | 13d. INSIDE C   | NO [           | 13e STREET ADDRESS<br>554 Nat | ional         | Highwa            | ay/21502                           |
| 14. FA        | ATHER'S NAME           |             | MIDDLF               | LAST                    |            |                 | MAIDEN NAA     | ME MIDDLE                     |               |                   |                                    |
| E             | Alb                    |             | . Roden              |                         |            |                 |                | ura V. Goss                   |               | LA                | AST                                |
|               | WAS DECEASED EVER      | IN U.S. AR  |                      | 166 SOCIAL SECU         | RITY NO.   | 17 INFORMA      |                | ADDRE                         |               |                   |                                    |
|               | YES, NO OR UNKNOWN)    | (IF YES GIV | E WAR OR DATES)      | 214-05-                 | 9649       | Mrs.            | losephir       | ne Rodenhau                   | Ser.          | LaVale            | MD-wif                             |
|               | 18 CAUSE OF DEAT       | H (Enter on | ly one couse per     |                         |            | 1               |                | )                             | -             |                   | XIMATE INTERVAL<br>ONSET AND DEATH |
| 40            | PART I. DEATH W        |             | D BY.<br>E CAUSE (o) | In trac                 | cer-       | e how           | he             | emor/he                       | se            | 15                | chours                             |
| Y.            | 1. No. 1. C            |             |                      | RAS A CONSEQUE          | NCE OF     | ^               |                | ,                             | )             |                   |                                    |
|               | Conditions, if any     | , which     | ( (b) (              | eve nr                  | o vas      | iula            | r de           | seare                         |               | 12                | 4 con                              |
| 50            | gove rise to imm       |             | DUE TO O             | R AS A CONSEQUE         | NCE OF     |                 |                |                               | 8 E3          |                   | 1                                  |
|               | underlying couse       | lost        | (c)_                 |                         |            |                 |                |                               |               |                   |                                    |
|               | PART 2 OTHER SIGN      | VIFICANT (  | ONDITIONS CO         | ONTRIBUTING TO E        | DEATH BUT  | NOT RELATED     | TO THE TERMI   | INAL DISEASE OR CON           | DITION GI     | VEN IN PART 1     | la                                 |
| NO            |                        |             |                      |                         |            |                 |                |                               |               |                   |                                    |
| CERTIFICATION | 190 DATE OF OPERA      | TION        | 196 COND             | ITION FOR WHICH         | OPERATIO   | N WAS PERFO     | RMED           | 20a AUTOPSY?                  | 206. IF YE    | S, WERE FINDI     | INGS USED                          |
| TIE           |                        |             |                      |                         |            |                 |                | YES NO                        |               | IFYING CAUSES     | NO [                               |
| CER           | 210 ACCIDENT WAS UNE   | _           | 21b. TIME O          | F INJURY<br>M. MONTH DA | V VEAD     | 21c HOW IN      | IURY OCCURR    | ED (ENTER NATURE OF INJUI     | RY IN ITEM 1B | PART I OR PART 2) |                                    |
| AL            | OR CONTRIBUTING        |             |                      | M. MONTH DA             | 19         |                 |                |                               |               |                   |                                    |
| MEDICAL       | 21d INJURY OCCUR       | RED         | 21e PLACE            |                         |            | 211 LOCATIO     | N              | CITY OR TO                    | NA/AI         | COUNTY            | STATE                              |
| ×             | WHILE NOT WE AT WO     | RK -        | (AT HOME STI         | REET FACTORY OFFICE F   | ARM ETC.}  | SIRECT          |                | CHTORIO                       | WN            | COOMIT            | STATE                              |
| 100           | 220.1 certify that (1) |             |                      |                         | 12-1       | f               | . 19.85        | , to 12-1                     | 9             | 198               | tho ( (we) lost                    |
|               | sow the decea          | ed olive on | 12 ~ 1               | ofter deam              | ) , 01     | nd that in      | our) opinion d | leath occurred on the do      | ate and hou   | or and from the   | couses stated                      |
|               | 226 SIGNATURE          | 1           | 0                    | D                       |            | DEGREE          | 13-1           |                               |               | 22c. DATE         | SIGNED                             |
|               | U                      | JU          | Lan                  | Jan                     | ul.        | LW &            | HYSICIAN       | MEDICAL STAF                  | IAN []        | 12-               | 19-85                              |
| 1             | 228 PHYSICIAN'S NA     | AME TYPE O  | R PRINT)             |                         |            | 22e ADDRES      | lemoria        | l Hospital                    | Medic         | al Buil           | lding                              |
|               | Dr. Willi              | am La       | mm                   |                         |            | ĺ               | umber1         | and, MD 215                   | 02            |                   |                                    |
|               | BURIAL, CREMATION,     | REMOVAL     | 23b. DATE            | 23c N                   | AME OF C   | EMETERY OR C    | REMATORY       | 23d LOCATION                  |               |                   |                                    |
| - {           | (SPECIFY)              |             |                      |                         |            |                 |                | CITY OR TOWN                  |               | COUNTY            | STATE                              |

TO FUNERAL DIRECTOR:

should be detoched with the State Dept

MPORTANT:

DHMH - 16 60M 7/84

24 FUNERAL DIRECTOR James F. Scarpelli, Cumberland, (VRA 15, 4)

Burial 12-22-1985 Rose Hill Cemetery

MD 21502

TY Cumberland Allegany
250. DATE REC'D. BY REGISTRAR 256 REGISTRAR'S SIGNATURE

STATE

executed within 24 hours ofter

ATTENDING PHYSICIAN: The low requires that the

retained by the haspital or attending physician.

TO HOSPITAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

## STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| REG. NO. |  |
|----------|--|
|          |  |

|         | 1 -            | REGISTRAR                          |               |                       |                                        | CERTIF     | ICATE OF DEATH                  | REG.                    | NO.                |                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|---------|----------------|------------------------------------|---------------|-----------------------|----------------------------------------|------------|---------------------------------|-------------------------|--------------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| -       |                | CEASED NAME                        | FIRST         |                       | MIDDLE                                 | ı          | AST                             | 20 DATE OF DEATH        | MONTH              | DAY YEAR          | 26 HOUR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|         | (ITPE          | OK PRINT)                          | Eldri         | ige                   | Ρ.                                     | Sa         | aville                          | December                | 6, 198             | 5                 | 6:50P M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|         | 3 SEX          | (                                  | 78            | 4 RACE                | Aug 17 Aug                             | 5. DATE C  |                                 | 6. AGE (IN YEARS LAST   | BIRTHDAY) .        | IF UNDER 1 YEAR   | IF UNDER 24 HRS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 1       |                | Male                               |               | Whi                   | te                                     | 04         | 27 93 PAR                       | 92                      | YRS                | MONTHS DAYS       | HOURS MIN.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 5       |                | RTHPLACE (STATE O                  | R FOREIGN     | 76. CITIZEN OF        | WHAT COUNTRY?                          | 8          | D NEVER MARRIED                 | 9 BALTIMORE CITY        |                    | OF DEATH          | CONTRACTOR OF THE PARTY OF THE |
|         |                | ugusta, W                          | . Va.         | USA                   |                                        | WIDOWE     |                                 | Allegany                |                    |                   | MD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| S       | 10 CI          | TY OR TOWN OF DI                   | EATH          |                       | HOSPITAL, NURSIN                       |            | OR OTHER INSTITUTION            | 120 USUAL OCCUPA        |                    |                   | F BUSINESS OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| į,      | C              | umberland                          |               |                       | lanor Nurs                             |            | Home                            | retired                 | II OF TOOKING EII  |                   | tile                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|         | USUA<br>13a. S | AL RESIDENCE (IF NO                | RSING HOME OF | OTHER INSTITUTION     | GIVE RESIDENCE BEFORE                  |            | 113d INSIDE CITY LIMITS?        | 13e.STREET ADDRES       | S / ZIP CODE       | 015               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 1       |                | aryland                            |               | Legany                | Cumberl                                |            | YES X NO                        |                         |                    |                   | land, Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 1       | 14. FA         | THER'S NAME                        |               | WIDDLE                | LAST                                   |            | 15. MOTHER'S MAIDEN NAM         | ME<br>MIDDLE            |                    | LAS               | ,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|         |                | Willia                             | m             | Τ.                    | Saville                                |            | Harriet                         | _                       |                    | Wolford           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| d       |                | VAS DECEASED EVE                   |               | MED FORCES?           | 166. SOCIAL SECU                       | RITY NO.   | 17 INFORMANT                    | ADE                     | RESS               |                   | V                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|         |                | _ yes                              |               | W I                   | 217-10-4                               | 146        | Lions Manor N                   | Nursing Ho              | ne, Cumb           | erland            | Md.21502                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| N       |                | 18 CAUSE OF DEA                    | TH (Enter a)  | nly ane cause per     | ling for (a), (b), and                 | dicut      |                                 |                         |                    | APPROX<br>BETWEEN | MATE INTERVAL<br>ONSET AND DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|         |                | PART I. DEATH                      |               | D BY:<br>TE CAUSE (a) | theum                                  | omia       | *                               |                         |                    |                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|         |                |                                    |               | DUE TO, O             | R AS A CONSEQUE                        | NGE OF     |                                 |                         |                    |                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|         |                | Conditions, if an                  |               | ( (b)                 | Semil                                  |            |                                 |                         |                    |                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|         |                | gave rise to in<br>cause (a), stat | ing the       | DUE TO, O             | R AS A CONSEQUE                        | NCE OF     |                                 |                         |                    |                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|         |                | underlying cau                     | se last.      | ( (c)_                |                                        |            |                                 |                         |                    |                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|         | -,             | 0                                  |               |                       | ONTRIBUTING TO D                       | EATH BUT   | NOT RELATED TO THE JERM         | INAL DISEASE OR CO      | NDITION GIV        | EN IN PART        | a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| part of | CERTIFICATION  | Deep                               | vei           |                       | some s                                 | 15.        |                                 | .t Concin               |                    | 7 COC             | on                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 1       | ICA.           | 19a DATE OF OPER                   | ATION         | 196. COND             | ITION FOR WHICH                        | OPERATIO   | N WAS PERFORMED                 | 20a AUTOPSY?            |                    | WERE FINDI        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|         | RTIF           |                                    |               | 2 44 544              |                                        |            |                                 | YES NO                  |                    | s 🗌               | NO 🗆                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| d       |                | 210. ACCIDENT WAS U                | _             | 440010                | M. MONTH DA                            | Y YEAR     | 214 HOW INJURY OCCURE           | RED (ENTER NATURE OF IT | IJURY IN ITEM 18 P | ART 1 OR PART 2)  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|         | MEDICAL        | (IF EITHER NOTIFY ME               | DICAL EXAMINE | P. P.                 |                                        | 19         |                                 |                         |                    |                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|         | MED            | 21d INJURY OCCU                    | RRED          | 21e PLACE             | OF INJURY<br>REET, FACTORY, OFFICE, FA | ARM, ETC ) | 21f LOCATION<br>STREET          | CITY OR                 | TOWN               | COUNTY            | STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|         |                | AT WORK AT W                       | ORK           |                       |                                        | 101        | 0.0                             | 10/1                    |                    | 0 ~~              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|         |                | 22a.l certify that (               |               |                       |                                        | 85%        | nd that in (my) (aur) apinion ( | , to                    | alasta asaal bass  |                   | that (I) (we) last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|         |                | abave, (I) (we)                    | (did) (did no | t) view the bady      | after death.                           | , 01       |                                 | death accurred on the   | date and had       |                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|         |                | 1/A                                | Kom           | Horn                  |                                        |            | DEGREE ATTENDING                | MEDICAL S'              | AFF _              | 22c. DATE         | SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|         |                | 22d. PHYSICIAN'S I                 | MAME ITYPE    | 11001                 |                                        |            | PHYSICIAN [                     | DIRECTOR PHY            | SICIAN             |                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|         |                | naa                                | //            | ithan, M              | D                                      |            |                                 | No II                   |                    | 11                | . W1 0150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|         | 00.0           |                                    |               |                       |                                        | IAME OF S  | Lions Manor                     | Nursing H               | ome, cum           | berland           | 1, Ma.2130                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|         |                | SURIAL, CREMATION                  |               |                       |                                        |            | EMETERY OR CREMATORY            | CITY OR TOWN            | 4 978              | COUNTY            | STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|         | 24 FI          | BUTIA<br>INERAL DIRECTOR           | 1             | 12-09                 | -1985 I Su                             | nset       | Memorial Park                   | E REC'D. BY REGISTRA    | and A              | Llegany           | MD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

MD 21502

BP. DHMH - 16 60M 7/B4 (VRA 15, 4)

James F

Scarpelli, Cumberland

TO FUNERAL DIRECTOR. After this certificate has been signed by the should be detached for use as the buriol-transit permit. Then please remainship the State Dept. at Health and Mental Hygiene prior to burial, cremat MAPORTANT: If them 21 is marked or them 18 shows any injury, or other transitions.

24 FUNERAL DIRECTOR

James F. Scarpelli, Cumberland, MD 21502

DHMH - 16 60M 7/84

(VRA 15, 4)

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

ight STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE - STATE 347047 CERTIFICATE OF DEATH REGISTRAR REG. NO 26 HOUR4:30 I DECEASED NAME 20. DATE OF DEATH MONTH (TYPE OR PRINT) December 5, 1985 HENRY SHAFER RUSSELL 4 RACE 6 AGE (IN YEARS LAST BIRTHDAY) 3. SEX 5. DATE OF BIRTH Dec. 8, DAY 1896 Male White TO BIRTHPLACE ISTATE OR FOREIGN 76. CITIZEN OF WHAT COUNTRY? **BALTIMORE CITY OR COUNTY OF DEATH** MARRIED NEVER MARRIED cowa. USA Allegany DIVORCED [ 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 120 USUAL OCCUPATION 10 CITY OR TOWN OF DEATH 126 KIND OF BUSINESS OR (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) TYPE OF WORK FOR MOST OF WORKING LIFE! INDUSTRY Ret.Owner Memorial Hospital Auto Parts Cumberland 13a STATE 13b COUNTY 13e STREET ADDRESS / ZIP CODE 13d INSIDE CITY LIMITS? 507 Conrad Ave. 21502 MD Allegany Cumber land 14 FATHER'S NAME 15 MOTHER'S MAIDEN NAME LAST Clinton Shafer Nancy Frye ADDRESS 60 WAS DECEASED EVER IN U.S. ARMED FORCES? 16h SOCIAL SECURITY NO. 17 INFORMANT IVES NO OR UNKNOWN) (IF YES GIVE WAR OR DATES) 213-12-9773 Shafer, Cumberland, Anna MD NO APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 CAUSE OF DEATH (Enter only one couse PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE Conditions, if ony, which gove rise to immediate couse (a), stating the DUE TO: OR AS A CONSEQUENCE OF underlying couse lost.

> CERTIFICATION 190 DATE OF OPERATION 196 CONDITION FOR WHICH OPERATION WAS PERFORMED 20a AUTOPSY? 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? NO [ 210 ACCIDENT WAS UNDERLYING 21b. TIME OF INJURY 216 HOW INJURY OCCURRED (ENTER NATURE O HOUR A.M. MONTH DAY YEAR OR CONTRIBUTING CAUSE OF GEATH MEDICAL LIF EITHER NOTIFY MEDICAL EXAMINER) 21d INJURY OCCURRED 211 LOCATION 21e. PLACE OF INJURY COUNTY STATE (AT HOME, STREET, FACTORY, OFFICE FARM, ETC.) NOT WHILE 120.1 certify that (1) (this happital) attended to and that in (my) (our) apinion death accurred on the date and hour and from the causes stated 776 SIGNATURE DEGREE 22r. DATE SIGNED ATTENDING MEDICAL STAFF DIRECTOR PHYSICIAN 22d. PHYSICIAN'S NAME ITYPE THE PERSON Memorial Hospital Med. Bldg. Cumberland, MD 21502 Dr. G. Fiscus

> > 23c. NAME OF CEMETERY OR CREMATORY

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110

DHMH - 16 60M 7/B4

BP

d b

William G. Kight (VRA 15, 4)

230 BURIAL, CREMATION, REMOVAL

Cumberland, MD

23b. DATE

Dec. 8, 1985 Hillcrest Burial P. Cumberland Allegany MD

|               | 36          | 8, 1096   | .001       | 93200    | Lale    |
|---------------|-------------|-----------|------------|----------|---------|
|               |             | , ha a    |            | 48U      | Va.     |
| elusi ofu.    | Ret.Owne    |           |            |          |         |
| ad Ave. 21502 | 507 Conr    | χ         | Cumberland | Allegany | (Li     |
| eyr"          |             | Mancy     | Shafer     | n        | Clinton |
| cland, in     | fer, Cumber | anna Shar |            |          | V.1     |

Burial Dec.8,1985 Millerest Burial P. Cumberland Allegany MD William G. Kight Cumberland, MD

# FOR

WV

CATION

 $\infty$ 

FATHER'S NAME

William

# STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| - STATE<br>REGISTRAR                         |                                           | CERTIFICATE OF   | DEATH        | REG. NO.                                                  |                 |          |       |
|----------------------------------------------|-------------------------------------------|------------------|--------------|-----------------------------------------------------------|-----------------|----------|-------|
| ECEASED NAME FIRST PE OR PRINT)  MICHA       | EL B. S                                   | HEPARD           |              | DECEMBER 22, 19                                           | DAY YEAR        | 051      |       |
| EX                                           | 4 RACE                                    | 5. DATE OF BIRTH |              | 6. AGE (IN YEARS LAST BIRTHDAY)                           | IF UNDER A YEAR | IF UNDER |       |
| Male                                         | Cau                                       | June 25          | 1970         | 15 YRS                                                    | MONTHS DAYS     | HOURS    | MIN.  |
| BIRTHPLACE (STATE OR FOREIGN                 | 76 CITIZEN OF WHAT COUNTRY?               | MARRIED NEVER    | MAPPIED X    | 9 BALTIMORE CITY OR COUNT                                 | Y OF DEATH      |          |       |
| shington, D.C.                               | U.S.A.                                    |                  | NORCED       | ALLEGANY                                                  | - 38            |          | MD    |
| CITY OR TOWN OF DEATH                        | 11. NAME OF HOSPITAL, NURSIN              |                  | TITUTION     | 120 USUAL OCCUPATION  (TYPE OF WORK FOR MOST OF WORKING L | 126 KIND O      | F BUSINE | SS OR |
| CUMBERLAND                                   | MEMORIAL HOSPI                            |                  |              | Student                                                   |                 |          |       |
| UAL RESIDENCE IF NURSING HOME. STATE 136 CO. | OR OTHER INSTITUTION GIVE RESIDENCE BEFOR | E ADMISSION)     | CITY LIMITS? | 13e STREET ADDRESS / ZIP COD                              | E               | 196      | 1/31  |

15 MOTHER'S MAIDEN NAME

FIRST

Susan

| (YES, NO OR UNKNOWN)   (IF YES, GIVE WAR OR DATES) |                                                        | 166 SOCIAL SECURITY NO. 17 INFORMANT         |                              |            |          | W.       | Douglass St |                                                 |
|----------------------------------------------------|--------------------------------------------------------|----------------------------------------------|------------------------------|------------|----------|----------|-------------|-------------------------------------------------|
|                                                    | No                                                     |                                              | 800-04-6870                  | William A. | Shepard  | Reading, | PA          | 19601                                           |
|                                                    | 18 CAUSE OF DEATH<br>PART I. DEATH W.                  | I (Enter only one couse per<br>AS CAUSED BY: | line to (10), (b), and ic Ca | ilure-     | WE STALL |          | F           | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|                                                    | Conditions, if ony, gove rise to imm couse to, stoting | which (b)                                    | R AS A CONSEQUENCE OF        |            |          |          |             |                                                 |
|                                                    | underlying cause                                       |                                              |                              |            |          |          |             |                                                 |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

Keyser

Shepard

Minera

MIDDLE

A.

160 WAS DECEASED EVER IN U.S. ARMED FORCES? 166 SOCIAL SECURITY NO.

| =   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | THE RESIDENCE OF THE PARTY OF             |                         | YES NO                 | YES 🗌                        | NO 🗌  |
|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------------------------|------------------------|------------------------------|-------|
| CER | 210. ACCIDENT WAS UNDERLYING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 21b. TIME OF INJURY                       | 21c HOW INJURY OCCURRED | ENTER NATURE OF INJURY | IN ITEM 18 PART   OR PART 2) |       |
| 14  | OR CONTRIBUTING CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | HOUR A.M. MONTH DAY YEAR                  | NA                      |                        |                              |       |
| 2   | (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | P.M. (~\/\ 19                             |                         |                        |                              |       |
| 8   | 21d INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (AT HOME STREET FACTORY OFFICE FARM ETC.) | 211. LOCATION<br>STREET | A ) / A CITY OR TOW    | N COUNTY                     | STATE |
| Z   | WHILE AL WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | AT HOME STREET PACIFICATION OF PARM ETC.) | 311001                  | MIN                    |                              |       |
|     | and the state of t | 12                                        | 7.5185                  |                        |                              |       |

sow the deceased alive and that in (my) (our) opinion death accurred on the date and hour and from the causes stated DEGREE DIRECTOR PHYSICIAN

224 PHYSICIAN'S NAME (TYPE OR PRINT) DR. SHAN NATHAN

PHYSICIAN

HOSPITAL, CUMBERLAND, MD 21502

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

| 23a. BURIAL, C | REMATION, REMOV. | AL 23b. DATE |
|----------------|------------------|--------------|
| (SPECIFY)      | ation            | 12/28        |

23c. NAME OF CEMETERY OR CREMATORY Omps Cremation Service

23d. LOCATION CITY OF TOWN Winchester

Rt 2 Box 63

MIDDLE

R.

COUNTY STATE

Barse

24 FUNERAL DIRECTOR Craig Rotruck 85 S Main St Keyser, WV

85

DHMH - 16 60M 7/84 (VRA 15, 4)

TW TOT

A CARL STREET, AS A STREET, AS A

STATE OF MARYLAND

Tenda List Det. 1,181 110

the state of the s

son as and contract that the same as and as and

. mines . The date of the contract of the cont TOTAL STEELING TOTAL TOTAL TOTAL CONTROL OF THE STEELING TOTAL STE

STATE OF THE PERSON OF THE PER

Land Townson Time a

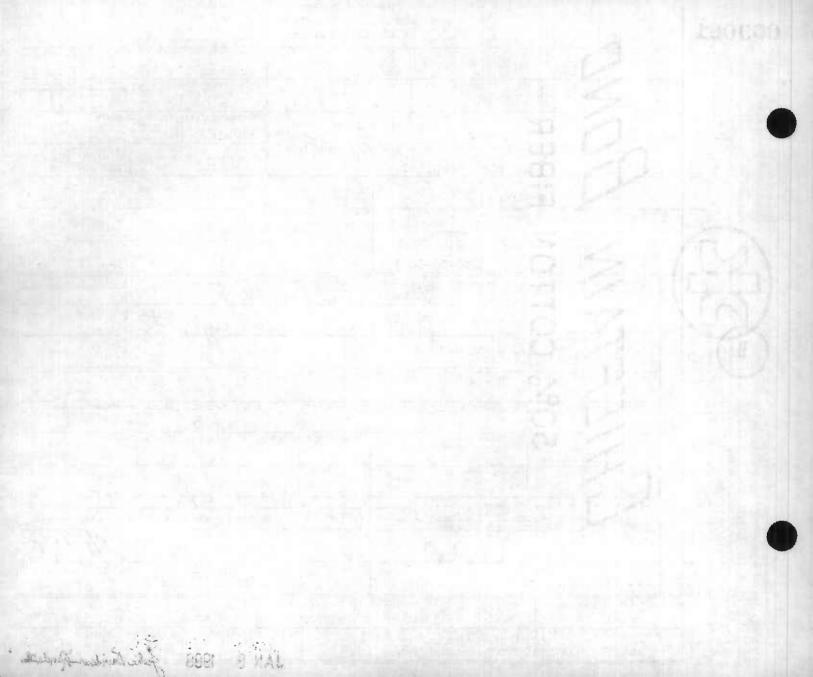
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| Female  White  S. DATE OF BIRTH  MONTH  DAY  15 DATE OF BIRTH  MONTH  DAY  16 AGE (IN YEARS LAST BIRTHDAY)  MONTHS DAYS HOURS AND  MONTHS DAYS HOURS AND  MONTHS DAYS HOURS AND  ALTIMORE CITY OR COUNTY OF DEATH  COUNTRY:  MARRIED   NEVER MARRIED   9 BALTIMORE CITY OR COUNTY OF DEATH  ALTIMORE CITY OR COUNTY OF DEATH  ALTIMORE CITY OR COUNTY OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |   | FOR<br>STATE<br>REGISTRAR                                                                     | DI                    |                     | EALTH AND MENTAL HYC  | GIENE REG. NO.                      | Q fina                                     | 0 / 1                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|-----------------------------------------------------------------------------------------------|-----------------------|---------------------|-----------------------|-------------------------------------|--------------------------------------------|---------------------------|
| TVA MUREL  SHOEMAKER  December 31, 1985  1.35EX  Female  White  Dec. 9 1934  51 Person of the property of the  | 1 |                                                                                               | MIDDLE                | ı                   | AST                   |                                     | ONTH DAY YEAR                              | 26 HOUR                   |
| Female  White  Dec. 9 1934  51 vs  Dec. 9 1934  51 vs  BAITIMORE CITY OR COUNTY OF DEATH  WARRIED  Dec. 9 1934  BAITIMORE CITY OR COUNTY OF DEATH  WARRIED  DEC. 9 1934  BAITIMORE CITY OR COUNTY OF DEATH  WARRIED  DEC. 9 1934  BAITIMORE CITY OR COUNTY OF DEATH  WARRIED  DEC. 9 1934  BAITIMORE CITY OR COUNTY OF DEATH  WARRIED  DEC. 9 1934  BAITIMORE CITY OR COUNTY OF DEATH  WARRIED  DEC. 9 1934  BAITIMORE CITY OR COUNTY OF DEATH  WARRIED  DEC. 9 1934  BAITIMORE CITY OR COUNTY OF DEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OF DEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OF BEATH  RESUDENCE (I PROMOSO COUNTY OF BEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OF BEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OF BEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OF BEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OF BEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OF BEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OF BEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OF BEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OF BEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OF BEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OF BEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OF BEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OF BEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OF BEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OF BEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OF BEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OF BEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OF BEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OF BEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OF BEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY OWN OR COUNTY OF BEATH  WE SUJAI OCCUPATION  ITHE OWN OR COUNTY O |   |                                                                                               | MUREL                 | SHOI                | EMAKER                | December 31                         | , 1985                                     | 7:35 PM                   |
| Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |   | 3 SEX                                                                                         | 4 RACE                |                     |                       | 6 AGE (IN YEARS LAST BIRTHE         |                                            |                           |
| The standard of the standard   | , | Female                                                                                        | White                 | / -                 |                       | 51                                  |                                            | S HOURS MIN.              |
| West Virginia  U.S.A.    WOODWED   DMORED   DMORED   DIVIDITION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1 |                                                                                               | 76 CITIZEN OF WHAT CO | JNTRY? 8            | NEVER MARRIED         | 9 BALTIMORE CITY OR                 |                                            |                           |
| Memorial Hospital   Sual Residence   Probleme Form of clief profit county   | 7 |                                                                                               | U.S.A.                |                     |                       | Allegany                            |                                            | MD.                       |
| It county   It c   | 9 | Cumberland                                                                                    | Memorial Hos          | spital              | OR OTHER INSTITUTION  | TYPE OF WORK FOR MOST OF W          | VORKING LIFE) 126 KIND<br>INDUSTR<br>ROCKI | OF BUSINESS OR POULTRY MI |
| Clarence  Barr  Grace  Wilfong  158 WAS DECEASED EVER IN U.S. ARMED FORCES?  158 WAS DECEASED EVER IN U.S. ARMED FORCES?  159 WAS DECEASED EVER IN U.S. ARMED FORCES?  150 WAS DECEASED EVER IN U.S. ARMED FORCES?  151 WAS DECEASED EVER IN U.S. ARMED FORCES?  152 CAUSE OF DEATH HERE only one coure per line for 10.1 lb), opd 10.  152 CAUSE OF DEATH HERE only one coure per line for 10.1 lb), opd 10.  153 CAUSE OF DEATH HERE only one coure per line for 10.1 lb), opd 10.  154 CAUSE OF DEATH HERE only one coure per line for 10.1 lb), opd 10.  155 CONDITION OF AS A CONSEQUENCE OF  156 DUE TO, OR AS A CONSEQUENCE OF  157 ON OR AS A CONSEQUENCE OF  158 DUE TO, OR AS A CONSEQUENCE OF  159 DUE TO, OR AS A CONSEQUENCE OF  150 DUE TO, OR AS A CONSEQUENCE OF  159 DUE TO, OR AS A CONSEQUENCE OF  150 DUE TO, OR | 1 |                                                                                               |                       |                     |                       | 13e STREET ADDRESS / 2<br>176 South | IP CODE<br>High Stree                      | 9994                      |
| 18 CAUSE OF DEATH (Enter only one couse per line for 10), ib. opd (c. )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1 | FIRST                                                                                         | _                     |                     | FIRST                 |                                     | Wilfor                                     | last<br>ng                |
| 18 CAUSE OF DEATH   Enter only one couse per line for io.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 2 |                                                                                               |                       | AL SECURITY NO.     |                       |                                     |                                            |                           |
| PART 1. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE TO!  DUE TO, OR AS A CONSEQUENCE OF  DUE TO, OR AS A CONSEQUENCE OF  Underlying couse 10st terming the couse 10st terming couses 10st  | 1 | No                                                                                            | 236-5                 | 0-0661              | Cheryl Rotru          | ick, 330 Wirg                       | man Ave.,                                  | Romney, WV                |
| OR CONTRIBUTING CAUSE OF DEATH P.M. 19  21d INJURY OCCURRED  21d INJURY OCCURRED  21d INJURY OCCURRED  22d IN MALE ALWORK ALWORK  220. I certify that (b) (this hospital deepensed from obove, (l) (we) (did) (did not) view the productive death.  22b. SIGNATURE  22d. PHYSICIAN'S NAME  Dr. Peter Halmos  22d. PHYSICIAN'S NAME  Dr. Peter Halmos  22d. NAME OF CEMETERY OR CREMATION, REMOVAL 1/3/86  23d. NAME OF CEMETERY OR CREMATORY  Purgitsville Hampshire WV                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |   | gove rise to immediate couse IoI, stating the underlying couse lost  PART 2 OTHER SIGNIFICANT | ( (c)                 | nseouence of        |                       | 0 *                                 | TION GIVEN IN PART                         | 1(a                       |
| OR CONTRIBUTING CAUSE OF DEATH HOW A.M. MONTH DAY YEAR  (IF EITHER, NOTIFY MEDICAL EXAMINER)  21d. INJURY OCCURRED  21d. INJURY OCCURRED  21d. INJURY OCCURRED  22d. PLACE OF INJURY  22d. I certify that (I) (this hospital attended the deceosed from sow the deceosed olive on obove, (I) (we) (did) (did not) view the trudy after death.  22d. PHYSICIAN DIRECTOR PHYSICIAN DIREC | 1 | 190 DATE OF OPERATION                                                                         | 196 CONDITION FOR     | WHICH OPERATION     | N WAS PERFORMED       | - >                                 | IN CERTIFYING CAUS                         | ES OF DEATH?              |
| 270.1 certify that (I) (this hospital attended to deceased from 19 19 10 19 19 10 19 19 10 19 19 10 19 19 10 19 19 10 19 19 10 19 19 10 19 19 10 19 19 10 19 19 10 19 19 10 19 19 10 19 19 10 19 19 10 19 19 10 19 19 10 19 19 10 19 19 10 19 19 10 19 19 10 19 19 10 19 19 10 19 19 19 19 19 19 19 19 19 19 19 19 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 7 | 00 00 100 100 100 100 100 00 00 00                                                            | EATH HOUR A.M. MON    |                     | 2)c. HOW INJURY OCCUR | RED (ENTER NATURE OF INJURY I       | N ITEM 18, PART 1 OR PART 2                | )                         |
| sow the deceosed olive on obove, (I) (we) (did) (did not) view the budy ofter depth.    19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |   |                                                                                               | 21e. PLACE OF INJURY  | OFFICE, FARM, ETC.) |                       | CITY OR TOWN                        | COUNTY                                     | STATE                     |
| ATTENDING DIRECTOR PHYSICIAN DIR |   | sow the deceased alive a above, (I) (we) (did) (did n                                         | 12/31                 | 19_ <del></del>     | /                     | death occurred on the date          | ond hour and from th                       | ne couses stated          |
| Dr. Peter Halmos  Cumberland, MD 21502  236 BURIAL, CREMATION, REMOVAL |   | H                                                                                             | alu                   | W                   | M ATTENDING PHYSICIAN | DIRECTOR   PHYSICIA                 | N                                          | 1/86                      |
| Burial 1/3/86 Old Pine Cemetery Purgitsville Hampshire WV                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |   | Dr. Peter Hal                                                                                 | mos                   |                     | Cumb                  | rial Hospital<br>erland, MD 21      | l & Medical<br>1502                        | 1'Center                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |   |                                                                                               |                       |                     |                       | CITY OF TOWN                        | COUNTY                                     | STATE                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |   |                                                                                               |                       |                     |                       |                                     |                                            |                           |

TO FUNERAL DIRECTOR: DHMH - 16 60M 7/84 (VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RALDIRECTOR Keith S. Shaffer
NAME
Shaffer Funeral Home, Romney, WV



### FOR STATE REGISTRAR

### STATE OF MARYLAND DEPARTMEN

| T | OF  | HEALT | H AND | MENTAL | HYGIEN |
|---|-----|-------|-------|--------|--------|
| F | RTI | FICA  | TE OF | DEATH  |        |

| REG. N      | 10.   |     |      |          |   |   |
|-------------|-------|-----|------|----------|---|---|
| TE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | ٨ | Ī |

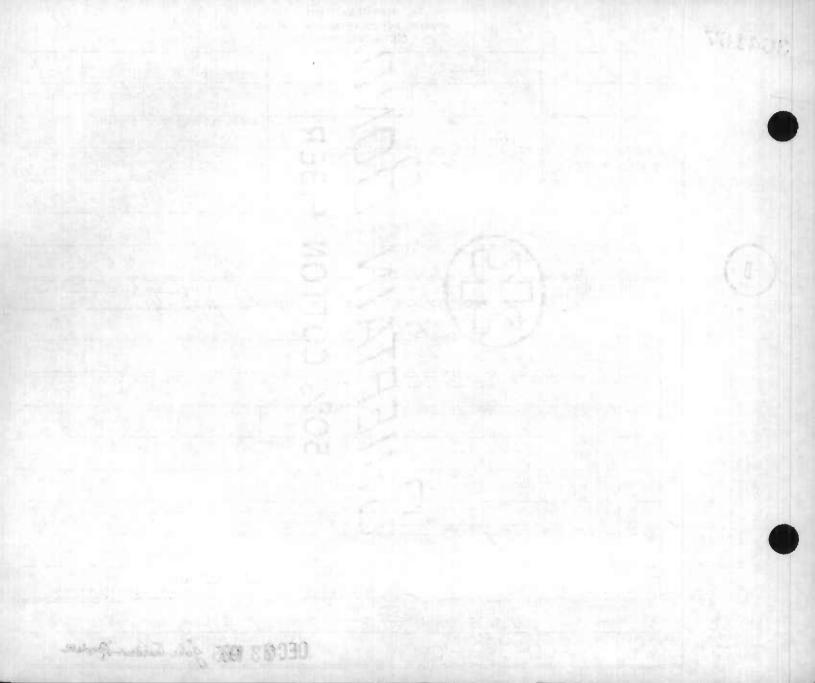
| he 72 hours ofter death                                                |                                                                              | Disself.                                               |
|------------------------------------------------------------------------|------------------------------------------------------------------------------|--------------------------------------------------------|
| and 2 should be wided with                                             | 1                                                                            | からからかりのとうから                                            |
| 1                                                                      | lo.                                                                          | 4, the medical                                         |
| Then please remove corbonal                                            | rte Dept. of Heolth and Mental Hygiene prior to burial, cremation, or remain | S shows any injury, or other troumotic event the medic |
| etached for use as the buriof-tronsit permit. Then please remove corbo | ith and Mental Hygiene prior                                                 | morked or Item 18 shows any                            |
| etoched for use                                                        | te Dept. of Hec                                                              | T. If Hem 21 is m                                      |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84 (VRA 15, 4)

| Buria           |        | 12/ | 21/ | 85      | wes. |
|-----------------|--------|-----|-----|---------|------|
| INERAL DIRECTOR |        |     |     |         |      |
| haffer Fune     | eral H | ome | . F | Romnev. | VW   |

|               | OR PRINT)                          |                    |                 | <b>TT 1100T</b> |                   | MEM             | 4                     | D 1              | 10                 | 10       | 0.5         | ,                                          | 0.100      | Α        |
|---------------|------------------------------------|--------------------|-----------------|-----------------|-------------------|-----------------|-----------------------|------------------|--------------------|----------|-------------|--------------------------------------------|------------|----------|
|               |                                    |                    | ELWOOD          |                 |                   |                 | December 18, 1985     |                  |                    |          | 5 9:20      |                                            |            |          |
| 3 SE          |                                    | 1                  | RACE            |                 | 5 DATE            | OF BIRTH        | YEAR                  | & AGE (IN YE)    | ARS LAST BIRTHD    | (4)      | MONTHS      | DAYS                                       | HOURS      | MIN.     |
| -             | Male                               |                    | Whi             | te              | Aug.              | 14. 1           | 909                   | 76               |                    | YRS.     |             |                                            |            |          |
|               | IRTHPLACE (STATE OF                | FOREIGN 7          | b CITIZEN OF    |                 | TRY? 8.           | ED NEVER        | AAADDIED 🗍            | 9 BALTIMOR       | E CITY OR          | OUNT     | Y OF DE     | ATH                                        |            |          |
|               | WV                                 |                    | U.S.            | Α.              | WIDOW             |                 | NORCED                | A1               | legany             | ,        |             |                                            |            | MD.      |
| 10 C          | ITY OR TOWN OF DE                  | ATH                | 1. NAME OF      | HOSPITAL, NI    | URSING HOME       | OR OTHER INS    | TITUTION              | 120 USUAL O      | CCUPATION          |          |             |                                            | F BUSINE   |          |
| 1             | Cumberlan                          |                    |                 |                 | il Höspi          |                 | -55                   | Contr            | ractor             | ORKING L | IFE)   INDI | Con                                        | stru       | ctio     |
| 3a.           | AL RESIDENCE IN NUR<br>STATE<br>WV | 13b COUN'<br>Hamps | TY              | 13c CITY OR     |                   | 13d INSIDE      | NO X                  | Rt. 1            | DDRESS / Z<br>Box  | IP COD   | E<br>A      | 9                                          | 99         | 4        |
| 14 F          | ATHER'S NAME<br>FIRST              |                    | IDDLE           | 145             | v                 | 15 MOTHER       | S MAIDEN NA           | ME               | WIDDIE             |          |             |                                            |            |          |
|               | Ace                                | Albe               |                 | Smit            | h                 |                 | Ada                   |                  | WIDDE              | M        | Malco       | lm                                         | 10         |          |
|               | WAS DECEASED EVE                   |                    |                 | 166 SOCIAL      | SECURITY NO.      | 17 INFORM       |                       |                  | ADDRESS            |          |             |                                            |            | LIVI     |
| _ '           | YES, NO OR UNKNOWN)                | (IF YES, GIVE      | WAR OR DATES)   | 214-05          | 5-9085            | Edith           | Smith,                | Star F           | ≀t. 1,             | Вох      |             |                                            |            |          |
|               | 18 CAUSE OF DEA                    | TH (Enter only     | y one couse per | line for 191.   | b), and ice       | 1               | 1                     | 1-               | -                  | #        | BE          | TWEEN                                      | MATE INTER | DEATH    |
|               |                                    |                    | CAUSE (0)       | not i           | talle.            | uchom           | uc ca                 | deany            | Lopas              | My       |             |                                            |            |          |
|               |                                    |                    | DUE TO, O       | R AS A CONS     | EQUENCE OF        |                 |                       |                  | /                  | 0        |             |                                            |            |          |
|               | Canditians, if on                  |                    | (b)_            | Deal            | etes              |                 |                       |                  |                    |          |             |                                            |            |          |
|               | gave rise to im                    |                    | DUE TO O        | RASACONS        | SEQUENCE OF       |                 |                       |                  |                    |          |             |                                            |            |          |
|               | underlying caus                    | e last             | (c)             |                 | SEO GENTLE ON     |                 |                       |                  |                    |          |             |                                            |            |          |
|               | PART 2 OTHER SIG                   | INIFICANT CO       | ONDITIONS C     | ONTRIBUTING     | G TO DEATH BUT    | T NOT RELATE    | D TO THE TERM         | INAL DISEASE     | OR CONDIT          | ION GI   | VEN IN P    | ART 110                                    | 1          |          |
| CERTIFICATION |                                    |                    |                 |                 |                   |                 | N.                    |                  |                    |          |             |                                            |            |          |
| CA            | 190 DATE OF OPERA                  | ATION              | 196 COND        | ITION FOR W     | HICH OPERATIO     | ON WAS PERF     | DRMED                 | 20a AUTO         |                    |          |             | WERE FINDINGS USED<br>ING CAUSES OF DEATH? |            |          |
| TIF           |                                    |                    |                 |                 |                   | 1.5             |                       | YES 🗌            | NO                 |          | ES 🗌        |                                            | NO [       |          |
| CE            | 21a. ACCIDENT WAS UN               |                    | 216. TIME C     |                 | H DAY YEAR        | 21c. HOW II     | NJURY OCCURE          | RED (ENTER NATI  | URE OF INJURY IP   | ITEM IB  | PART I OR F | PART 2)                                    |            |          |
| AL            | OR CONTRIBUTING                    |                    |                 | M. MOITH        | 19                |                 |                       |                  |                    |          |             |                                            |            |          |
| EDICAL        | 21d. INJURY OCCUP                  | RRED               |                 | OF INJURY       |                   | 21f. LOCAT      |                       |                  | CITY OR TOWN       |          | cou         | 12.47.4                                    |            | TATE     |
| ×             | WHILE NOT W                        | ORK ORK            | (AT HOME ST     | REET, FACTORY O | FFICE, FARM ETC } | STREE           |                       |                  | CITY OR TOWN       |          | 000         | 11411                                      | 5          | IAIE     |
|               | 220.1 certify that (I              | ) (this hospite    | al) ottended th | e deceased f    | rom               |                 |                       | , to             | 1011               |          | 19          |                                            | hat (l) (v | we) last |
|               | saw the decea<br>abave, (1) (we)   | sed alive an       | view the hady   | ofter death     | 19, o             | and that in (my | ) (aur) apinion (     | death occurred   | an the date        | and har  | ur and fro  | om the                                     | auses sta  | oted     |
|               | 226. SIGNATURE                     | 1                  |                 |                 |                   | DEGREE          |                       |                  |                    |          | 220         | DATE                                       | SIGNED     |          |
|               | 1401                               | Mon                | - 1             |                 |                   |                 | ATTENDING PHYSICIAN X | MEDICAL DIRECTOR | STAFF<br>PHYSICIAL | 4        | 1           | 2/1                                        | 8/85       | ,        |
|               | 274. PHYSICIAN'S N                 | AME TYPE OR        | PRINT)          | TIME            |                   | 22e ADDRE       | 55                    | ical Bu          |                    |          |             |                                            | W          |          |
|               | Dr. H.C.                           | Merri              | ck              |                 |                   | Memor           | ial Hos               |                  |                    |          | A MA        | 2                                          | 1502       |          |
| 23o. I        | BURIAL, CREMATION                  | REMOVAL            | 23h DATE        |                 | 23c NAME OF C     |                 |                       | 23d LOCAT        | ION                | Tall     | U JYO       | - 4                                        |            |          |
|               | SPECIFY  Buria                     |                    | 12/21/          | 85              |                   |                 | Cemete                | ry Pr            | oints              | Han      | npshi       | re                                         | WÝ         | TATE     |
|               | 1701 41                            |                    | 1.2,217         |                 |                   | -1.ap 01        | 30000                 | 4                |                    |          | -1          |                                            |            |          |



| 53169                  |                           | FOR<br>STATE                                           |                              | DEPARTMENT OF H                     | HEALTH A      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4,                 | 3                      | 2 3 .                      | 1 5             |
|------------------------|---------------------------|--------------------------------------------------------|------------------------------|-------------------------------------|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|------------------------|----------------------------|-----------------|
| 207.22                 | and the same              | REGISTRAR                                              | ME                           | DICAL EXAMINI                       | ER'S CE       | RTIFICATE O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                    | REG. NO.               |                            |                 |
|                        |                           | CEASED NAME FIRST<br>E OR PRINT)                       |                              | WIDDIE                              | LAS           | sř                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | OF                 | ESTI-                  | MONTH DAY YE               |                 |
| V. RRESTON STREET,     |                           | Ceci                                                   |                              | M. Spa                              |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    | H MATED                | 12 5 198                   |                 |
|                        | 1. SEX                    | 4. RACE                                                | 5. DATE OF BIRTH             | 6. AGE (IN YEA<br>YEAR LAST BIRTHDA |               | ER 1 YR. IF UNDER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 24 HRS. 2c. DA     |                        |                            | EAR 2d HOUR     |
|                        | Re                        | male White                                             | Aug. 23                      | ,1902 83 YR                         | S.            | 1,00,0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | DEA                | AD                     |                            | 85 11:20 M      |
| 1                      | 7a. B1                    | RTHPLACE (STATE OR REIGN COUNTRY)                      | 76. CITIZEN OF W             | HAT COUNTRY?                        | 8 MARRIED     | NEVER MARRIE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ED X 9. BALT       | MORE CITY OR           | COUNTY OF DEATH            | 1               |
| 1                      | -                         | Maryland                                               | U.S                          | .A.                                 | WIDOWED       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    | legany                 |                            | MD.             |
| 1                      | 10. CI                    | TY OR TOWN OF DEATH                                    |                              | SPITAL, NURSING HOME,               | , OR OTHER    | NOITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 12a USUAL OCC      | UPATION (TYPE OF       | F WORK 126 KIND OF OR INDI |                 |
| А                      |                           | Frostburg                                              |                              | Broadway                            |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    | visor                  | U.S.G                      |                 |
| £.                     |                           | AL RESIDENCE (IF IN NURSING HOME O                     | ROTHER INSTITUTION, C        | IVE RESIDENCE BEFORE ADMISSIO       |               | Id INSIDE CITY LIMITS?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 13e. STREET ADD    |                        |                            |                 |
| 1                      | 2007                      |                                                        | eganta                       | Frostbur                            |               | YES NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                    | oadway                 | . 21532                    |                 |
| 7                      |                           | ATHER'S NAME                                           | MIDDLE                       | IAST                                |               | 5. MOTHER'S MAIDE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                    | MIDDLE                 | LAST                       |                 |
|                        | 1                         | Frank                                                  | P.                           | Spates                              |               | Marga                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ret                |                        | Carney                     |                 |
| M                      | 16a. V                    | VAS DECEASED EVER IN U.S. AR                           | MED FORCES?<br>WAR OR DATES) | 166. SOCIAL SECURITY                | 'NO. 17       | . INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                    | ADDRESS                |                            |                 |
|                        |                           | Bo (IF YES, GIVE                                       | WAR OR DATES)                | 2211-60-61                          | 79            | Frank S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | netes.             | Westmi                 | nister,                    | Cal.            |
| 8                      |                           | 18. CAUSE OF DEATH (Enter on                           | ly one couse per lin         |                                     |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Parons             | NOS UNIX               | APPROXI                    | MATE INTERVAL   |
|                        |                           | PART I DEATH WAS CAUSED                                | JBY:                         | actorione                           | Pero          | lir Car                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | dina               | reselas                | BETWEEN                    | INSET AND DEATH |
| AVC.                   | 33                        | IMMEDIA                                                |                              | R AS A CONSEQUENCE C                | )F            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    |                        |                            |                 |
| 110. ST<br>M<br>14. FA | Canditians, it any, which |                                                        | Pisca                        | 0                                   |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    | 100                    |                            |                 |
|                        |                           | gove rise to immediate<br>cause (a) stating the under- | DUE TO, O                    | R AS A CONSEQUENCE C                | )F            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    |                        |                            |                 |
|                        |                           | lying couse lost.                                      | (4)                          |                                     |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    |                        |                            |                 |
|                        |                           | PART 2 OTHER SIGNIFICANT CONDITIONS                    | CONTRIBUTING TO DEATH        | H BUT NOT RELATED TO THE TERMI      | NAL DISEASE O | R CONDITION GIVEN IN PAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | PT 1 a             |                        |                            |                 |
| X                      | Z                         |                                                        |                              |                                     |               | TOTAL |                    |                        |                            |                 |
| ı                      | ATIO                      | 190. DATE OF OPERATION                                 | 19b. COND                    | ITION FOR WHICH OPERA               | ATION WAS     | S PERFORMED?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                    |                        | 20 AUTOR                   | PSY?            |
| ſ                      | FIC                       | In the second                                          |                              |                                     |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    |                        | YES [                      | NO (X           |
| ž                      | ER                        | 210 EXTERNAL CAUSE WAS                                 | 21b. TIME C                  |                                     | 21c. HOV      | V INJURY OCCURRE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | D (ENTER NATURE OF | INJURY IN ITEM 18 PAR' |                            | NOUN            |
| 3                      |                           | UNDERLYING OR CONTRIBUTING CAUSE OF I                  |                              | M. MONTH DAY YEAR                   |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    |                        |                            |                 |
| 1                      | DIC                       | 214 INTURY OCCURRED                                    | 21e PLACE                    | OF INJURY (AT HOME.                 | 211. LOCA     | ATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                    |                        |                            |                 |
|                        | ME                        | WHILE NOT WHILE DAT WORK                               | STREET, FAI                  | CTORY, FARM, ETC.)                  | STRE          | EET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | CITY OR            | OWN                    | COUNTY                     | STATE           |
|                        |                           | AT WORK - AT WORK                                      |                              |                                     |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    |                        |                            |                 |
|                        |                           | 22a I certily that I took charg                        | e of the remoins de          | scribed abave, held an              | Autopsy       | , Inspection                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Inqui              | y La, ond in           | n my apinian               |                 |
| 17                     |                           | death resulted fram: Natur                             | rol causes 4.                | Accident, Suit                      | cide .        | Hamicide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Undetermined       | monner,                |                            |                 |
|                        |                           | ACTUAL                                                 | VOILAL-                      | an Vare                             | -             | TITLE (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    |                        | DATE 17-6                  | -05             |
| t                      |                           | SIGNATURE                                              | www                          | a juje                              | M.D.          | Vepuly                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | MEDICAL EXA        | MINER                  | SIGNED 12-5                | 07              |
| 1                      | - 7                       | EXAMINER'S NAME -                                      |                              | N D                                 |               | 000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Caton I            | Da C. 111              | mhomlomá                   | Ma              |
| 1                      |                           | (TYPE OR PRINT) Fran                                   |                              |                                     |               | DKE 33                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                    |                        | mberland                   | i, Md.          |
| 1                      | 23e B                     | URIAL, CREMATION, REMOVAL 2                            |                              | 23c. NAME OF CEM                    | METERY OR O   | CREMATORY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 23d. LOCATION      |                        | COUNTY                     | STATE           |
|                        |                           | Burial                                                 | Dec 918                      | 5 St. Mic                           | hael          | s Cem                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Frost              | burg.                  | Allegany                   | Md.             |
|                        | 24. F                     | UNERAL DIRECTOR                                        | ADDRES                       | 55                                  |               | 750. DATE R                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | REC'D. BY REGISTI  | AR 256. REGISTE        | RAR'S SIGNATURE            |                 |
|                        |                           | Durst Fune                                             | ral Hom                      | e, Frostbu                          | rg, 1         | Md                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | A MED              | guiadan                | Idon Bondas                | 0               |
|                        | -                         |                                                        |                              | THY THE                             |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    | 0                      |                            |                 |

El Elizab arvoll N.V - rouly was: the design with the second of The state of the s AND THE REPORT OF THE PARTY OF and the state of t

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | FOR                                                                                                                               | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                        | 3 2 3 7 4                                    |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--|
| 364099                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | - STATE<br>REGISTRAR                                                                                                              | MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                          | REG. NO.                                     |  |
| 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1. DECEASED NAME FIRST                                                                                                            | MIDDLE LAST 2a. DATE KI                                                                                                          | NOWN MONTH DAY YEAR 26 HOUR                  |  |
| 2 3 3 3 5 E 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Wil                                                                                                                               | lie C Sponaugle DEATH A                                                                                                          | 12 21 185 1055                               |  |
| PLEA<br>FICTO<br>STREET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 3 SEX 4 RACE                                                                                                                      | DATE OF BIDTH                                                                                                                    | MONTH DAY YEAR 2d. HOUR                      |  |
| ON SOUR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Male Cau                                                                                                                          | 8 26 05 80 YRS. DEAD                                                                                                             | 12 21 185 1055                               |  |
| NECESSARY, PLEASI<br>UNERAL DIRECTOR<br>S FOR YOUR FULES<br>Y PLETON STREET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                         | MARRIED W NEVER MARRIED                                                                                                          | RE CITY OR COUNTY OF DEATH                   |  |
| S NECESSARY, PLEASE FUNERAL DIRECTOR. E 5 FOR YOUR FILES. DIWITHIN 72 HOURS W HEESTON STREET,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | W. Va.                                                                                                                            | USA WIDOWED DIVORCED ATTE                                                                                                        | gany                                         |  |
| Y IS<br>GE GE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | IU CITY OR TOWN OF DEATH                                                                                                          | (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FOR MOST OF WORKIN                                                                |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Cumberland USUAL RESIDENCE (IF IN NURSING HOME O                                                                                  | Memorial Hospital Bottler                                                                                                        | Ret. Breweing Co                             |  |
| 1個には 1万万                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 130 STATE 13b. COUN                                                                                                               | TY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e STREET ADDRESS                                                                 | St. 23502                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Maryland All                                                                                                                      | egany CumberInd YES NO 1 701 Elm                                                                                                 | Street 21502                                 |  |
| # Kng 95 //                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Ashby                                                                                                                             | MIDDLE LAST FIRST MIDI                                                                                                           |                                              |  |
| MOR<br>NOS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 160 WAS DECEASED EVER IN U.S. AR                                                                                                  | Sponaugle Mary C.  MED FORCES?   166. SOCIAL SECURITY NO.   17. INFORMANT                                                        | Munlix ADDRESS                               |  |
| AATE<br>NEP<br>NEP<br>NEP<br>NEP<br>NEP<br>NEP<br>NEP<br>NEP<br>NEP<br>NE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (YES, NON PUNKNOWN) (IF YES, GIVE                                                                                                 | war or DATES) 214-05-4778 Corda Sponaugle                                                                                        | Same as above                                |  |
| 2 NO. 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 18 CAUSE OF DEATH (Enter on                                                                                                       | ly one couse per line for (o), (b), and (c).)                                                                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PM ST<br>PM ST | PART I DEATH WAS CAUSEI                                                                                                           | DBY:<br>TECAUSE (o) Cardio-pulmonary arrest                                                                                      | sudden                                       |  |
| STON<br>N 24<br>N ITE<br>ALOI<br>SIT PEI<br>AOVA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1 8880                                                                                                                            | DUE TO, OR AS A CONSEQUENCE OF                                                                                                   |                                              |  |
| MER SANS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Conditions, if any, which gave rise to immediate                                                                                  | ) (b) Hepato-renal failure                                                                                                       | 2-3 week                                     |  |
| 201 W. PRESTON UTED WITHIN 24 IN PENCIL IN ITE IN PENCIL IN ITE INAL - TRANSIT PEN O MENTAL HYGIE DN, OR REMOVA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | couse (o) stating the <u>under</u> lying cause lost.                                                                              | DUE TO, OR AS A CONSEQUENCE OF                                                                                                   | vears                                        |  |
| M J=M=00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | DART & GENERAL CACHICICANIA CONOUTIONS                                                                                            | (c) <u>Chronic alcoholic liver disease</u>                                                                                       |                                              |  |
| RECORDS,  ILD BE EXECT PENDING,  * MEDICAL D AS A BUR HEALTH ANI L, CREMATIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Id |                                                                                                                                  |                                              |  |
| PEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Chronic sub-du                                                                                                                    | ral hematoma; coronary artery heart disease;                                                                                     | chronic neart lailure                        |  |
| F VITAL TE SHOU WORD " TE CHIEF TE CHIEF TO BE USE ENI OF F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Chronic sub-du                                                                                                                    |                                                                                                                                  | YES NOXX                                     |  |
| OF V                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 210 EXTERNAL CAUSE WAS                                                                                                            | 216. TIME OF INJURY HOUR A.M. MONTH DAY YEARD+ foll at home Sub-dura                                                             | Y IN ITEM 18 PART 1 OR PART 2)               |  |
| DIVISION OF VITAL RE E: THIS CERTIFICATE SHOULD IE, WRITING THE WORD "FE IS WARARDED TO THE CHIEF A IS NACE 3 SHOULD BE USED, STATE DEPARTMENT OF HE, O, 21201 PRIOR TO BURIAL, O, 21201 PRIOR TO BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | UNDERLYING OR CONTRIBUTING CAUSE OF                                                                                               | UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 400 P.M. 11 8 185 to 10 10 10 10 10 10 10 10 10 10 10 10 10                            |                                              |  |
| IVISI<br>CERT<br>TINC<br>DED<br>DEP<br>DEP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | UNDERLYING OR CONTRIBUTING CAUSE OF I                                                                                             | 216 PLACE OF INJURY (AT HOME, SIREET, FACTORY, FARM, ETC.)  STREET, FACTORY, FARM, ETC.)  STREET                                 | COUNTY STATE                                 |  |
| #34×4E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | WHILE NOT WHILE DAT WORK                                                                                                          | AT WORK AT WORK 11/8/85 701 Elm Street. 12/10/85 3 South Memorial Hospital                                                       |                                              |  |
| ATE, ORV, ORV, ND,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 220. I certify that I look charg                                                                                                  | 220. I certify that I look charge of the remains described above, held an Autapsy , Inspection XX, Inquiry XX, and in my opinion |                                              |  |
| BE I THIT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | death resulted frami: Natur                                                                                                       | death resulted frage: Natural couse XX, Accident , Suicide , Homicide , Undetermined monner ,                                    |                                              |  |
| MARY WAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ACTUAL ACTUAL                                                                                                                     | TITLE (SPECIFY)  Dn ty                                                                                                           | DATE 12/21/85                                |  |
| SEAT FEET FEET FEET FEET FEET FEET FEET F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | SIGNATURE Paul S                                                                                                                  | now, M.D. Dpty MEDICAL EXAMIN                                                                                                    | VER SIGNED 12/21/05                          |  |
| MED AND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                   | morial Hospital ADDRESS Cumberland Ma                                                                                            | ryland 21502                                 |  |
| TO MEDICAL EXAMINER: TI<br>EXECUTE THE CERTIFICATE,<br>PAGE 4 SHOULD BE FORW<br>TO FUNEAL DIRECTOR: PAFTER DEATH, WITH THE STA<br>BATTIMORE, MARYLAND, 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 230. BURIAL, CREMATION, REMOVAL 2                                                                                                 |                                                                                                                                  | COUNTY STATE                                 |  |
| 07/84 BP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Burial D                                                                                                                          | ec. 24 1985PLeasant Grove C Cumbera                                                                                              | COOTTI STATE                                 |  |
| 25M DHMH - 17                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 24. FUNERAL DIRECTOR                                                                                                              | ADDRESS 250. DATE REC'D. BY REGISTRAR                                                                                            | 256 REGISTRAR'S SIGNATURE                    |  |
| (VR A15 ME (5))                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | William G. Kic                                                                                                                    | tht Cumberland, MD                                                                                                               | Q.                                           |  |

N. Va. USA

Bottler Ret. Brewing Co.

21502

Ashby Sponaugle Lary C. Lunlix

Lo Corda Sponaugle Same as above

Burial Dec. 24, 1985PLeasant Grove C. Cumberkand Allegany AD

William G. Might Cumberland, AD

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 |                                  |                                  | ST                           | ATE OF A      | MARYLAND                  |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | an a                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------------|----------------------------------|------------------------------|---------------|---------------------------|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | FOR                             |                                  |                                  | DEPARTMENT O                 | HEALTH        | AND MENTAL                | HYGIENE                | 3 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2 3 / 3                                  |
| 0=0100                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | - STATE<br>REGISTRAR            |                                  | MEI                              | DICAL EXAMI                  | NER'S         | CERTIFICATE               | OF DEATH               | REG. NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                          |
| 353130                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1. DECEASED NA                  | AAF FIRST                        | T                                | MIDDLE                       |               | LAST                      | 2n DATE                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ONTH DAY YEAR 25 HOU                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (TYPE OR PRINT)                 |                                  | ,                                |                              | 01            |                           | OF                     | ESTI-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Signi Day 12 FIOO                        |
| A ASE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                 | Char                             |                                  | W.                           |               | nsberry                   |                        | MATED _                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 12-2 19 85                               |
| A TO SECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ) SEX                           | 4. RACE                          | 5. DATE OF BIRTH                 | 6. AGE (IN<br>YEAR LAST BIRT |               |                           | R 24 HRS. 2c. DAT      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | NIH DAY YEAR 2d. HOL                     |
| N 22 S S S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Male                            | White                            | Aug. 28.                         |                              |               | HOURS HOURS               | DEA                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 12-2 19 85 2:0                           |
| NECESSARY PEASE<br>UNFRAL DIRECTOR.<br>5 FOR YOUR FILES.<br>WITHIN 72 HOURS<br>VERSION STREET.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 70 BIRTHPLACE                   | (STATE OR                        | 76 CITIZEN OF WE                 | AT COUNTRY?                  | To To         | W-                        | 9 BALTI                | MORE CITY OR CO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OUNTY OF DEATH                           |
| SASES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | FOREIGN COUNTR                  | irginia                          | TI C A                           |                              |               | IED A NEVER MAR           | 11100                  | - Co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                          |
| A S S S S S S S S S S S S S S S S S S S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 10 CITY OR TOW                  |                                  | U.S.A                            |                              | WIDOV         |                           |                        | legany Co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                          |
| A HE S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | IU. CITY OR TOW                 | NOFDEATH                         |                                  | PITAL, NURSING HO.           |               | ER INSTITUTION            | FOR MOST OF WO         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | VORK 126 KIND OF BUSINESS<br>OR INDUSTRY |
| ACA TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Cumber                          | Land                             | Memoria                          | l Hospital                   |               |                           | Profe                  | ggar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | College                                  |
| - Onego                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                 |                                  | ME OR OTHER INSTITUTION, GI      |                              |               | 1                         |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                          |
| 8 38553                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Marylai                         | 13b. CC                          |                                  | 13c. CITY OR TOWN            |               | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDR       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                          |
| SS A A SS A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                 |                                  | legany                           | Frontbur                     | g             | YES NO                    | 13 Par                 | k Ave.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 21532                                    |
| * E-2 //                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 14 FATHER'S NA                  |                                  | MIDDLE                           | LAST                         |               | 15. MOTHER'S MAII         | DEN NAME               | MIDDLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | LAST                                     |
| W MARKA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | David                           | 1                                | F. St.                           | ansberry                     |               | Trevi                     | a                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Kinney                                   |
| S (SARWA)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 160. WAS DECEAS                 |                                  | ARMED FORCES? GIVE WAR OR DATES) | 16b. SOCIAL SECUP            | ITY NO.       | 17. INFORMANT             | Harris                 | TO ADDRESS TA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | VA. 26362                                |
| 5 ENTER!                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Yes                             |                                  | 49-52                            | 232-40-                      | 29/./.        | Records                   | Poisso                 | 1 Francis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1 II am a                                |
| 2 × 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 18 CALISE                       | OF DEATH (Foto                   | r anly one cause per line        | 1.232-40-                    | λ. R          | AFFW SE                   | neborry                | Funer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | AL HOME                                  |
| ST., I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | PARTI                           | DEATH WAS CAL                    | JSED BY:                         |                              |               |                           | msperry.               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | approximate interval                     |
| PRESTON ST<br>ITHIN 24 HOL<br>CIL IN ITEM 18<br>AN ALONG<br>ANSIT PERMI<br>AL HYGIENE,<br>REMOVAL.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 7 91                            | G MAME                           | DIATE CAUSE (o)                  | Multiple                     |               | ies                       |                        | Md                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                          |
| PRESTC<br>ITHIN 2-<br>CIL IN IT-<br>VER ALC<br>AL HYG<br>REMOV                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ///                             | 18                               |                                  | AS A CONSEQUENC              | E OF          |                           |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 77                                       |
| AAL KEA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                 | ians, it any, what rise to immed |                                  |                              |               |                           |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | cause                           | (a) stating the und              |                                  | AS A CONSEQUENC              | E OF          |                           |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                          |
| S, 201 W. CCUTED W. IL EXAMIL TEND MENT TION, OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | lying c                         | ause last.                       |                                  |                              |               |                           |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                          |
| DIVISION OF VITAL RECORDS, 201 W. PRESI S CERTIFICATE SHOULD BE EXECUTED WITHIN RITING THE WORD PENDING" IN PENCIL IN PEDED TO THE CHIEF ABICAL EXAMINER A E3 SHOULD BE USED AS A BUINAL - TRAINER E DEPARTAKENT OF HEALTH AND MENTAL HY OI PRIOR TO BURIAL CREMATION, OR REMO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | BART 2 OTHER                    | FIGNIFICANT CONOUT               | IONS CONTRIBUTING TO DEATH       | NIT HOT OF 1770 TO THE TO    |               |                           |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                          |
| EXE<br>MING<br>MATH<br>A BU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                 | SIGNIFICANT CONUTT               | TONS CONTRIBUTING TO DEATH       | BUT NOT KETYTED IN THE IS    | KWINAL DIZEAS | E OK CONDITION GIVEN IN I | PART 1 rail            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                          |
| CA A A SEE SE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 190. DATE O                     |                                  |                                  |                              |               |                           |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                          |
| TALE<br>COULT<br>CUSED<br>CUSED<br>CUSED<br>CUSED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 190. DATE 0                     | OF OPERATION                     | 19b. CONDIT                      | TION FOR WHICH OP            | ERATION W     | AS PERFORMED?             |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 20 AUTOPSY?                              |
| 1 X82555                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | =                               |                                  |                                  |                              |               |                           |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | YES XX NO                                |
| DIVISION OF VITAL S. CERTIFICATE SHOURTH OF THE WORD ROED TO THE CHIEF E. 3 SHOULD BE USE TO EPERARANT OF THE ROED TO BURILA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 21a. EXTER                      | VAL CAUSE WAS                    | 21b. TIME OF                     | INJURY<br>XMONTH DAY YE      | 21c. H        | OW INJURY OCCUR           | RED (ENTER NATURE OF I | NJURY IN ITEM 18 PART 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | OR PART 2)                               |
| N STAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                 | NG X OR                          | OF DEATH 2:00P.M                 | . $12-2$ 19                  | AR OF CIT     | hicat nine                | and haterna            | n nutron                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                          |
| S S S S S S S S S S S S S S S S S S S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | CONTRIBU<br>21d INJURY<br>WHILE | OCCURRED                         | 21e PLACE C                      | OF INJURY (AT HOME,          | 03 Su         | bject pinr                | led betwee             | il aucos                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                          |
| DIVISI<br>S CERI<br>REDED<br>SE 3 SF<br>TE DEP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | WHILE                           |                                  | STREET, FACT                     | ORY, FARM, ETC.)             |               | STREET                    | CITY OR TO             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | COUNTY STATE                             |
| HIS WRI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | AT WORK                         | NOT WHILE                        | AA rc                            | ad-east la                   | ne Rt         | 48 Cumb                   | erland, Al             | legany Co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | o., Maryland                             |
| T = 5 T T T T T T T T T T T T T T T T T                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 220. Lce                        | rtify that I tour                | harder of the remains des        | united above held on         | I Auton       | sy XX, Inspecti           | ion , Inquiry          | . O and in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | my apinian                               |
| 素があまる。                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                 | olted from N                     | $\mathcal{L}_{-}$ $\square$ /    | Accelent XXI7                | 1             | . Hamicide                | Undetermined m         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ny apinan                                |
| AAM<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>STEECHE<br>ST | dedili resi                     | offed from the                   | Harris Constant                  | Accepting the second         | suic pe       |                           | Undetermined #         | nanner,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                          |
| X8355                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ACTUAL                          | V .                              | 1/201 - 1                        | 1)//1013                     | 10            | A of The Ch               | 105                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ATE 12_2_85                              |
| A E E S E WAY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | SIGNATUR                        | E_//                             | an wall                          | 1 / MM                       | M_W           | Acting Ch                 | 116 WEDICAL EXA        | MINER S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ATE 12-2-85                              |
| NO STATE OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | EXAMINER                        | SNAME TI-                        | amaa D. Cust                     | LL MD                        |               | 111 0                     | Jann Ct                | DATES 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Md 21201                                 |
| TO MEDICAL E<br>EXECUTE THE<br>PAGE 4 SHO<br>TO FUNKAL<br>AFTER DEATH<br>BALTIMORE,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | EXAMINER<br>(TYPE OR P          | RINT) In                         | omas D. Smi                      | tn, M.D.                     |               | ADDRESS                   | enn St.,               | DATEU., I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Md. 21201                                |
| DXADA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 23a. BURIAL, CREN               | ATION, REMOVA                    | AL 236 DATE                      | 23c. NAME OF C               | EMETERY C     | R CREMATORY               | 23d LOCATION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | COUNTY STATE                             |
| 07/84 BP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | _                               | rial                             | Dec.6.198                        | Lawfo                        | rd Cer        | neterv                    | Norther                | ne Ritc                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 77 77                                    |
| 25M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 24. FUNERAL DIR                 |                                  | 1-00.01270                       |                              |               |                           | REC'D. BY REGISTR      | AR 256 REGISTRA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | R'S SIGNATURE                            |
| DHMH - 17<br>(VR A15 ME (5))                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | NAME<br>Danne                   | t Bunone                         | 1 Home, Fro                      | athana M                     | 27.6          | 32 050                    | 10                     | PA K.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | . Milese.                                |
| (AK WID WE (2))                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | DOT. 2                          | o runara                         | it mones Pro                     | PODUTE NA                    | TO WIT        | 32 DEC                    | 2339                   | The Part of the Pa |                                          |

Anla Witte Law. 25,1207 57

Anna Virginin Law.

Jund

Anna Charleng K

March Aller K

David L. Stensborry Crawle

ode. Louisman de l'abo

13 Per No., 21522

Buriel - Wee. 6, 1985 | Justone Commeny

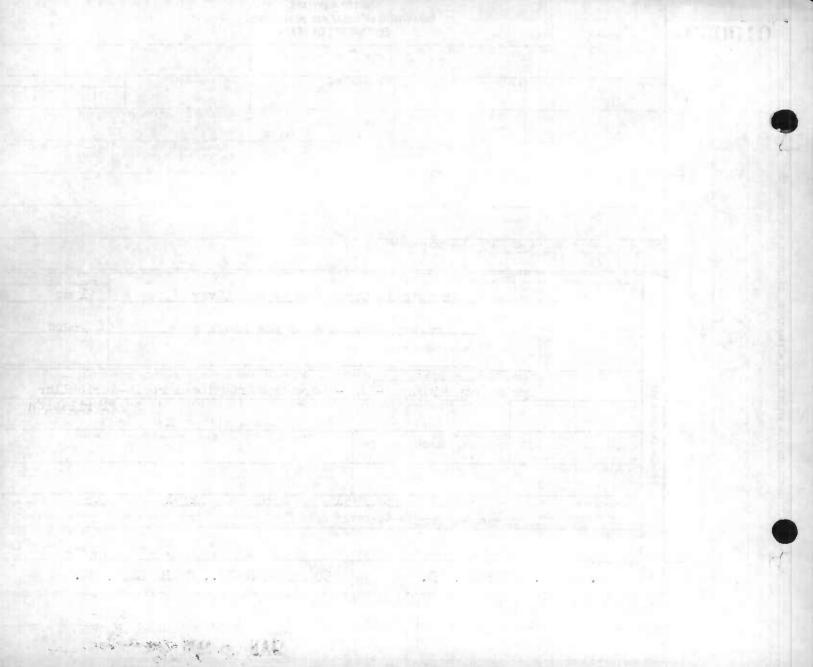
Downt France Local Prostering 10. 21593 (FO & Mar Jilotti se Nike

| DOFOOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1.            | FOR<br>- STATE                                                                    |                                            | DEPA                         | RTMENT OF H        | OF MARYLAND EALTH AND MENTAL ICATE OF DEATH | HYGIENE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 8 5                  | 3               | 2          | 1 6                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------|--------------------------------------------|------------------------------|--------------------|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-----------------|------------|-------------------------|
| 365225                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1 DE          | REGISTRAR CEASED NAME FIR                                                         | ST.                                        | MIDDLE                       |                    | AST                                         | 20 DA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | REG. NO.             | ONTH DAY        | YEAR       | 12b. HOUR               |
| ÷ 33                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |               | E OR PRINT)                                                                       |                                            |                              |                    |                                             | 70.00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                      |                 |            |                         |
| deod deod                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 3. SE         | Mart:                                                                             | Ln BI                                      | IRKE                         | Sha<br>Is. Date of | PO<br>F BIRTH                               | 6. AGE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (IN YEARS LAST BIRTH | 2 17<br>DAY) IF | 85         | 11:25 AA                |
| To softe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1             | MALE                                                                              | WHI                                        | ריחים                        | MONTH              | DAY YEAR                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 73                   |                 | THS: DAYS  | HOURS MIN.              |
| Pog dire                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |               | IRTHPLACE (STATE OR FOREIG                                                        |                                            | OF WHAT COUNTR               | MARC<br>8          |                                             | 9 BAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | TIMORE CITY OR       |                 | F DEATH    |                         |
| neral n 72                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |               | PA.                                                                               | US                                         | 3Δ                           | WIDOWE             | DIVORCED                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Allegan              | V               |            | MD.                     |
| er de                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 10 C          | ITY OR TOWN OF DEATH                                                              | 11. NAME C                                 |                              | SING HOME C        | ROTHER INSTITUTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | UAL OCCUPATION       | N               | 12h KIND O | F BUSINESS OR           |
| is of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |               | Cumberland                                                                        |                                            | ed Heart                     |                    | al                                          | RET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | RED KELL             | Y SPR           | INGFIE     | LD TIRE C               |
| how I how                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | USU<br>130.   | AL RESIDENCE (IF NURSING H                                                        | OME OR OTHER INSTITUT                      | ION, GIVE RESIDENCE BEF      |                    | 134, INSIDE CITY LIMIT                      | S? Use.STR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | REET ADDRESS / 2     | ZIP CODE        | 911        | 611                     |
| AND n 24                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |               |                                                                                   | LLEGANY                                    | CIMBERIA                     | AND                | YES NO                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | GEPHART              | DRIVE           | X/-        | 24                      |
| RYL within                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 114. F        | ATHER'S NAME<br>FIRST                                                             | MIDDLE                                     | tAST                         |                    | 15. MÖTHER'S MAIDER                         | NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | MIDDLE               |                 | LAS        | ir I                    |
| W. per dund                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |               | Н.                                                                                | HALL                                       | SHARP                        |                    | MARY                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ADDRES               | ì               | 1ARTIN     |                         |
| BALTIMORE the execution and care. Pooles wal. the medical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |               |                                                                                   | .S. ARMED FORCES<br>YES, GIVE WAR OR DATES |                              | CURITY NO.         | IT INFORMANT                                | ח פסב                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                      |                 | ~~~        |                         |
| TIM<br>Son or rs. Pe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |               | YES IW                                                                            | VII                                        | 220-10-                      | 4290               | MARIAN SHAF                                 | CG 202                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | GEPHART              | DRIVE           |            | KLAND MD.               |
| v requires that the different sens signed by the different plants that build then please reme. Then please reme to thousand the please reme to the please reme to the please of the plea | CERTIFICATION | gove rise to immedia<br>couse (o), stating<br>underlying couse to<br>PART 2. OTHE | DUE TO                                     | OR AS A CONSECUTION OF WHITE | TH BUT             | NOT RELATED THE                             | UH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | SEASE OR CONDI       | TION GIVEN      |            | 5811                    |
| L REC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | FF            |                                                                                   |                                            |                              |                    |                                             | YES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | _                    | IN CERTIFYII    | NG CAUSES  | OF DEATH?               |
| DF VITAI<br>CIAN: Th<br>physicion<br>Trificate I<br>Il-transe<br>tol Hygie                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | A M           | 210. ACCIDENT WAS UNDERLY                                                         |                                            | E OF INJURY<br>A.M. MONTH    | DAY YEAR           | 21c. HOW INJURY OC                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                      |                 | _          |                         |
| ON OF INSICIAL Physicial P | SAL           | OR CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL EX                               | OFDEATH                                    | P.M.                         | 19                 | hard suit in                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                      |                 |            |                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | MEDICAL       | 21d. INJURY OCCURRED                                                              | TAT HOME                                   | CE OF INJURY                 | * *****            | 211 LOCATION                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CITY OR TOWN         | 4               | COUNTY     | STATE                   |
| DIVIS Por after 11 Se as the colth and marked                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | -             | AT WORK NOT WHILE                                                                 | VI                                         |                              | lhun               | 16 5                                        | 20                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1401                 | 7               | ac         |                         |
| 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 123           | 22a I certify that (I) (this                                                      | 1 1/11/11                                  | 126 ened from                | 400                | 190                                         | , to.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Ow.                  | . 19            |            | that (1) (we) lost      |
| R ATTEN hospital hospital RECTOR RECTOR for used |               | SOW THE CONTROL OF                                                                | did not) view the bo                       | dy after death.              | P                  | that in (my) (our) ap                       | inion death of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | curred on the date   | e and hour a    | 22c, DATE  |                         |
| L OR the hit house to Dep                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | -10           | TATIVIL                                                                           | mus                                        |                              | W                  | ATTENDIN                                    | NG MEDI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ICAL STAFF           |                 | Dec.       | 18.1985                 |
| PITA<br>by<br>ERA<br>Stat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | +             | 22d. PHYSICIAN'S NAME                                                             | (TYPE OR PRINT)                            |                              | 1-1                | PHYSICIA<br>22e ADDRESS                     | AN DIREC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | TOR   PHYSICIA       | W []            | PEL,       | 10,1102                 |
| O HOSPITA etoined by TO FUNERA should be de with the Stot                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |               | DR TERRY WII                                                                      | LIAMS                                      |                              |                    | MEMORTAT, H                                 | OSPITA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | T MEDICAI            | DIITT           | DING (     | THE PERSON AS ASSESSED. |
| retoin<br>TO F<br>Shoul                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 230.          | BURIAL, CREMATION, REM                                                            |                                            | 22                           | R NAME OF C        | EMETERY OR CREMATO                          | to be de the state of the state | LOCATION             |                 |            | CUMBERLAND              |
| BP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |               | (SPECHY) BURTAT                                                                   |                                            |                              |                    | vn cemeterv                                 | -11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | VALE ALL             |                 | MARVI A    | STATE                   |
| DHMH - 16 50M 4/83                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |               | UNERAL DIRECTOR                                                                   |                                            |                              |                    | 250                                         | DATE REC'D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | BY REGISTRAR 25      | b. REGISTRA     | R'S SIGNAT | URE                     |
| (VRA 15, 4)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | S             | ILCOX-MERRITI                                                                     | FUNERAL                                    | SERVICE                      | CUMBERI            | AND MARY A                                  | NP.OZ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1000 4               | lie Dave        | - Por      | mobile "                |

Indicated intent forms Diggs for Aleginera

MD

230 Baltimore Ave. Cumberland.



| 20             |   |
|----------------|---|
| 2              |   |
| 9              |   |
| A              |   |
| Z              |   |
| A              |   |
| Z              |   |
| ., BALTIMORE,  |   |
| 0              |   |
| =              |   |
| A              |   |
| 80             |   |
| 10             |   |
| Z              |   |
| 0              |   |
| ES             |   |
| 8              |   |
| W. PRESTON ST. |   |
| =              |   |
| 20             |   |
| os,            |   |
| 2              |   |
| ECORD          |   |
| OK.            |   |
| ITAL           |   |
| =              |   |
| 4              |   |
| 0              |   |
| SION           |   |
| /IS            |   |
| 6              |   |
|                |   |
|                | _ |
|                |   |

STATE OF MARYLAND FOR DEPARTMENT OF HEALTH AND MENTAL HYGIE

| NE | 8 | 2)       | 3 | 2 | J   | 1 | 8 |
|----|---|----------|---|---|-----|---|---|
|    |   | REG. NO. |   |   | 75% |   |   |

|   | REGISTRAR                                                                                 |                                                                 | CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | REG. NO.                                               |                                                 |
|---|-------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------|
|   | 1 DECEASED NAME FIR                                                                       | ST MIDDLE                                                       | LAST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 20. DATE OF DEATH MONTH                                | DAY YEAR 26 HOUR                                |
|   | Marguer                                                                                   | rite E.                                                         | Stinger                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | December 24,                                           | 1985 7:08pw                                     |
|   | 3. SEX                                                                                    | 4 RACE                                                          | 5 DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6 AGE (IN YEARS LAST BIRTHDAY)                         | IF UNDER 1 YEAR IF UNDER 24 HRS                 |
| 1 | female                                                                                    | white                                                           | 03-26-1904                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 81 <sub>YR</sub>                                       |                                                 |
|   | 70. BIRTHPLACE (S ATE OR FOREIG                                                           | 76 CITIZEN OF WHAT COU                                          | MARRIED NEVER MARRIED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 9 BALTIMORE CITY OR COU                                | NTY OF DEATH                                    |
|   | MD                                                                                        | USA                                                             | WIDOWED DIVORCED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 077                                                    | MD.                                             |
|   | 10 CITY OR TOWN OF DEATH                                                                  |                                                                 | NURSING HOME OR OTHER INSTITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 120 USUAL OCCUPATION  (TYPE OF WORK FOR MOST OF WORKIN | 126 KIND OF BUSINESS OR                         |
|   | Cumberland                                                                                |                                                                 | sp. & Med. Bldg.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | supervisor                                             | telephone co                                    |
| 3 |                                                                                           | OME OF OTHER INSTITUTION GIVE RESIDENCE COUNTY 131 CITY OF CUME | TE BEFORE ADMISSION)  R TOWN  DETLAND  YES Y NO   NO   THE PROPERTY LIMITATION OF THE PROPERTY LIMITAT | 130.STREET ADDRESS / ZIP CO                            | ope<br>nic Street/21502                         |
| 1 | 14 FATHER'S NAME                                                                          | MIDDLE 14                                                       | 15. MOTHER'S MAIDE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | N NAME<br>MIDDLE                                       | LAST                                            |
|   | Clarence                                                                                  | F. Fraley                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | a Marie Sweitzer                                       | Indi                                            |
|   | 160 WAS DECEASED EVER IN U                                                                | YES GIVE WAR OR DATEST                                          | L SECURITY NO. 17 INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ADDRESS                                                |                                                 |
|   | no                                                                                        | 214-                                                            | 05-8994 Mr. Walter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | D. Stinger, Orla                                       | ando, FL - son                                  |
|   | 18 CAUSE OF DEATH (E)<br>PART I. DEATH WAS C                                              | nter only one couse per line to                                 | Samuel and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | and T                                                  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|   |                                                                                           | MEDIATE CAUSE (0)                                               | Wajnunny H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Truck!                                                 |                                                 |
|   |                                                                                           | DUE TO, OR AS                                                   | PRUSINES acidi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | mT                                                     |                                                 |
|   | Conditions, if any, wh                                                                    |                                                                 | Will amin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1//_                                                   |                                                 |
|   | cause (a), stating to<br>underlying cause la                                              | DUE TO, OR AS A ON                                              | OF OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                        |                                                 |
|   |                                                                                           | ANT CONDITIONS CONTRIBUTION                                     | NG TO DEATH BUT NOT RELATED TO THE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | TERMINAL DISEASE OR CONDITION                          | GIVEN IN PART 110                               |
| - | 4 190 DATE OF OPERATION                                                                   | 196 CONDITION FOR V                                             | WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20a AUTOPSY? 20b. IF                                   | YES, WERE FINDINGS USED                         |
|   | 190 DATE OF OPERATION                                                                     |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | YES NO NO                                              | RTIFYING CAUSES OF DEATH?  YES NO NO            |
|   |                                                                                           | 110110 111 11011                                                | TH DAY YEAR 21c HOW INJURY OC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | CCURRED (ENTER NATURE OF INJURY IN ITEM                | 18 PART 1 OR PART 2)                            |
|   | (IF EITHER NOTIFY MEDICAL EX                                                              | OF DEATH                                                        | 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                        |                                                 |
|   | OR CONTRIBUTING CAUSE  (IF EITHER NOTIFY MEDICAL EX  21d INJURY OCCURRED  WHILE NOT WHILE | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY,               | OFFICE FARM, ETC.)  211 LOCATION STREET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | CITY OR TOWN                                           | COUNTY STATE                                    |
|   | AT WORK AT WORK                                                                           |                                                                 | 1/1/21) 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | · Me 24                                                | GC                                              |
|   | 220 1 certify that (1) (this<br>sow the deceased of                                       | hospital strended the deceased                                  | 201                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | inion double and a the late                            | , 1900, that (h (we) lost                       |
|   | obgvg, (I) (we) (did) (                                                                   | did not wew the body ofter death.                               | DEGREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | inion death occurred on the date and                   | nour and from the causes stated                 |
|   | Mula                                                                                      | inis for Und                                                    | MMM W ATTENDIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | AN 📈 DIRECTOR 🗌 PHYSICIAN 🗍                            | 12-26-85                                        |
|   | Dr. Willi                                                                                 | am D. Lamm                                                      | 77e. ADDRESS Mem                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | orial Hospital Med<br>berland, MD 2150                 | dical Bldg.                                     |
|   | 230 BURIAL, CREMATION, REM                                                                | OVAL 23b. DATE                                                  | 23c. NAME OF CEMETERY OR CREMATO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ORY 23d LOCATION                                       |                                                 |
|   | (SPECIFY) Burial                                                                          | 12-27-1985                                                      | Hillcrest Burial F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Park Cümberland                                        | Al'l'ëgany MD''                                 |
|   | 24 ELINERAL DIRECTOR                                                                      |                                                                 | 15.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | DATE BEC'D BY BECIETBABISE DEC                         | CICTRADIC CICALATURE                            |

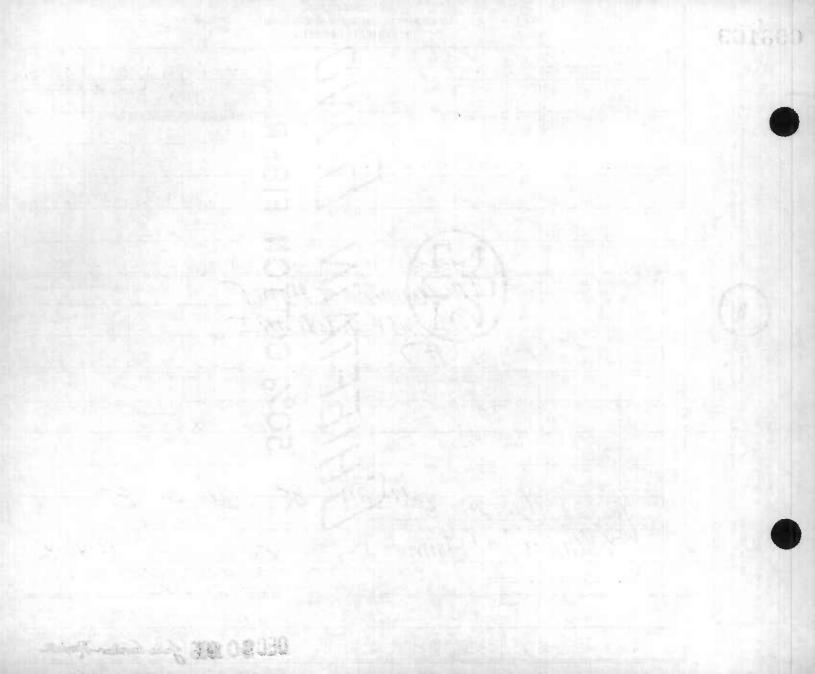
DHMH - 16 60M 7/84

TO FUNERAL DIRECTOR should be detoched for with the State Dept. of IMPORTANT: If them 2

(VRA 15, 4)

James F. Scarpelli, Cumberland, MD 21502

DECRO 185 Julianian Anten



BALTIMORE,

W. PRESTON ST.,

RECORDS

DIVISION OF VITAL

#### - STATE REGISTRAR 1. DECEASED NAME

female 7a BIRTHPLACE

10. CITY OR TOWN OF DEATH Cumberland 13a STATE

> (YES, NO OR UNKNOWN) no

MD 14 FATHER'S NAME

160 WAS DECEASED EVER IN U.S. ARMED

TYPE OR PRINTS

3. SEX

#### STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| 0 | 10.07 |  |
|---|-------|--|
|   |       |  |
|   |       |  |

| REGISTRAR                                                          |                                                       |                                      |                                               | CERTIF                 | ICATE OF DEATH                                | REG. N                                                   | 10.                   |                 |             |                |
|--------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------|-----------------------------------------------|------------------------|-----------------------------------------------|----------------------------------------------------------|-----------------------|-----------------|-------------|----------------|
| EASED NAME                                                         | FIRST                                                 |                                      | MIDDLE                                        | l.                     | AST                                           |                                                          |                       | DAY YEAR        | 2b. HOU     | R              |
| OK 7 KIRVI)                                                        | MILDR                                                 | ED                                   | LOUISE                                        | TA                     | ALLMAN                                        | December 2                                               | 7,1985                |                 | 9:45        | Am             |
| female                                                             |                                                       | i. race<br>Wh                        | ite                                           | S. DATE C              |                                               | 6. AGE (IN YEARS LAST BII                                | ^^                    | IF UNDER TYEAR  | IF UNDER    | 24 HRS<br>MIN. |
| OUNTRY) OH                                                         | E OR FOREIGN                                          |                                      | WHAT COUN                                     | TRY? 8  MARRIE  WIDOWE | D NEVER MARRIED                               | 9 BALTIMORE CITY O                                       | OR COUNTY             | OF DEATH        |             | MD.            |
| ry or town of berland                                              | DEATH                                                 | (IF NOT IN SU                        | HOSPITAL, NU<br>CHEACILITY, GIVE S<br>CIAL HO | JRSING HOME C          | OR OTHER INSTITUTION                          | 12a USUAL OCCUPAT<br>(TYPE OF WORK FOR MOST O<br>retired | ION                   |                 | F BUSINE    | SSOR           |
| L RESIDENCE (IF) TATE MD                                           | 13b COUN                                              |                                      | 13c. CITY OR                                  |                        | 13d INSIDE CITY LIMITS?<br>YES NO X           | 13e.STREET ADDRESS<br>Route 6                            |                       | 71/2150         | 2           |                |
|                                                                    | ames Kep                                              |                                      | LAST                                          |                        |                                               | zel Milliror                                             |                       | LAS             | 4           |                |
| 'AS DECEASED E'<br>ES, NO OR UNKNOWN<br>NO                         |                                                       | MED FORCES?<br>WAR OR DATES)         | 213-24                                        | -6668                  | Mrs. Ann Pr                                   | att, Cresapt                                             |                       | 1D - da         | ughte       | er             |
| Conditions, if a<br>gove rise to<br>cause (a), st<br>underlying co | IMMEDIATE  ony, which immediate tating the ause lost. | DUE TO, C  DUE TO, C  DUE TO, C  (c) | In To                                         | EQUENCE OF             | Congestive wie Chalian NOT RELATED TO THE TER | MINAL DISEASE OR CON                                     | Le DITION GIVE        |                 | MATE INTER  | J. A. I.       |
| 19a DATE OF OPE                                                    | ERATION .                                             | 196 COND                             | ITION FORWA                                   | HICH OPERATION         | N WAS PERFORMED                               | 20a AUTOPSY?                                             |                       | WERE FINDIN     |             |                |
| 21d INJURY OCC                                                     | CAUSE OF DEAT                                         | P<br>21e. PLACE                      |                                               | DAY YEAR<br>19         | 211. LOCATION<br>STREET                       | RRED (ENTER NATURE OF INJU                               | RY IN ITEM 18 PA      |                 |             | ATE            |
| 22a. I certify that                                                | t (1) (this hospite                                   |                                      | ne deceased fr                                | om mo                  |                                               | to                                                       | 1                     | 9               | that (I) (w | ve) lost       |
| sow the dec                                                        |                                                       | riew the body                        | after death.                                  |                        | 22e ADDRESS Memor                             | MEDICAL STA                                              | FF<br>CIAN□<br>1 Medi | 224. DATE       | 127         | fed for        |
| JRIAL, CREMATIC PECIFY) But                                        | rial                                                  | 23b. DATE<br>12-29                   |                                               |                        | eph Cemetery                                  | Midland                                                  | Alle                  | gany I          | MD ST       | ATE            |
| VERAL DIRECTOR                                                     | D                                                     |                                      |                                               |                        | 25 - DA                                       | TE DEC'D DY DECICTOAD                                    | DEC ICED              | A DIC CLOSELATE | 100         |                |

00 TO FUNERAL DIRECTOR: A should be detached for use with the State Dept. of Heo

BP DHMH - 16 60M 7/84 (VRA 15, 4)

230. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

CERTIFICATION

24 FUNERAL DIRECTOR Jämes F. Scarpelli, Cumber Tänd, MD 21502

Da. DATE REC'D. BY REGISTRARIZSB. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 2120

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

> 26 HOUR 7:05 an 12/11/20

REG. NO.

| gan'i | (TYPE OR PRINT) Louis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | e Bright Te                                                                                   | ter        |                                     | 12/1                                                    | 1/85                       |                                  | 7:05,                               |
|-------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|------------|-------------------------------------|---------------------------------------------------------|----------------------------|----------------------------------|-------------------------------------|
| 1     | Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4 RACE<br>White                                                                               | June       | 30, 1906                            | 6. AGE (IN YEARS LAST BI                                | YRS.                       | UNDER 1 YEAR                     | IF UNDER 24 HRS HOURS MIN.          |
| >     | 70 BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 76. CITIZEN OF WHAT COUNTRY?                                                                  | MARRIED [  | NEVER MARRIED DIVORCED              | 9 BALTIMORE CITY OF Allega                              |                            | DEATH                            | MD                                  |
| -     | Cumberland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING (IF NOT IN SUCH FACILITY, GIVE STREET AD 635 Apt. 4B            | Washi      | ngton St                            | 120 USUAL OCCUPAT<br>(TYPE OF WORK FOR MOST)<br>Housewi | OF WORKING LIFE)           | 126 KIND OI<br>INDUSTRY<br>Own F | F BUSINESS OR  Home                 |
|       | USUAL RESIDENCE (IF NURSING HOME OR 136 STATE 136 COUN Maryland All                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                               | 1136       | I. INSIDE CITY LIMITS?<br>ES 🔀 NO 🗌 | 13. STREET ADDRESS<br>635 Apt.                          | ZIP CODE<br>4B Wa          | sh.St                            | t./2150                             |
|       | 14 FATHER'S NAME<br>FIRST<br>Charles                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | E. Bright                                                                                     | 15.        | MOTHER'S MAIDEN N                   | Kather                                                  |                            | Rineh                            |                                     |
|       | 160 WAS DECEASED EVER IN U.S. AR. (YES NO ORUNKNOWN) (IF YES, GIV                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | CARTAG GO DATES                                                                               |            | Harry Te                            |                                                         | 512 Ho<br>ashing           |                                  | Road NV                             |
|       | Conditions, if any, which gave rise to immediate cause to), stating the underlying cause last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | DUE TO, OR AS A CONSEQUEN  DUE TO, OR AS A CONSEQUEN  DUE TO, OR AS A CONSEQUEN  (c) Moderate | CE OF      | in - Molon                          | utulion                                                 |                            |                                  |                                     |
|       | PART 2 OTHER SIGNIFICANT OF THE PROPERTY OF TH | 196. CONDITION FOR WHICH O                                                                    |            |                                     | 200 AUTOPSY?  YES NO                                    | 20b. IF YES, VIN CERTIFYIN | ERE FINDIN                       | IGS USED                            |
|       | OR CONTRIBUTING CAUSE OF DEA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | HOUR A.M. MONTH DAY                                                                           | YEAR<br>19 | E HOW INJURY OCCU                   | JRRED (ENTER NATURE OF INJU                             | IRY IN ITEM 18 PART        | 1 OR PART 2)                     |                                     |
|       | WHILE NOT WHILE AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 21e PLACE OF INJURY<br>LATHOME STREET, FACTORY, OFFICE, FAR                                   |            | STREET                              | CITY OR TO                                              | OWN                        | COUNTY                           | STATE                               |
|       | 22a.1 certify that (1) (this haspi<br>saw the deceased alive an<br>obave, (1) (we) (did) (did no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | tal) attended the deceased from                                                               | , and th   |                                     | n death accurred an the o                               |                            |                                  | that (I) (we) last<br>couses stated |
|       | 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | uh.                                                                                           | DEG        | ATTENDING<br>PHYSICIAN              |                                                         |                            | 22c. DATE                        | SIGNED                              |

22e ADDRESS

231 NAME OF CEMETERY OR CREMATORY

DHMH - 16 60M 7/84 (VRA 15, 4)

24 FUNERAL DIRECTOR

23a BURIAL, CREMATION, REMOVAL

Burial

FOR STATE

REGISTRAR

DECEASED NAME

John J. Hafer, Jr. LaVale, MD

Merrick

12/13/85

Memorial

Queens Point Ceme. Keyser

Cumberland, Maryland

Hospital . Medical

in Daydon-Randelle

21502

ainstea Sent to the state of the state Charles and 655 /c. 48 Weshington It. Housewille Own Force Section 111 and the Line and we handwidth the first brestynes. deind introduction deind orthogonal section No Trouble C 5 Herry tobox, r. Mashington, 1.0. T. I of 666, intigno, I learned John M. M. Heldich I. S. Serie . . . Surial - 12/18/85 tomesme Point Come. Merson, Mineral, No. 15. John J. Haten, Jr. Mayele, J.

| 006152                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1.            | FOR<br>STATE<br>REGISTRAR                                                |                                   |                      | DEPART                                      | MENT OF H    | EALTH AND     | MENTAL HYG           | IENE 3               | REG. N        | ن<br>۱٥.    | 2                                        | <b>3</b>                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------|-----------------------------------|----------------------|---------------------------------------------|--------------|---------------|----------------------|----------------------|---------------|-------------|------------------------------------------|------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | CEASED NAME                                                              | FIRST                             |                      | MIDDLE                                      | 1.           | AST           |                      | 20. DATE C           | OF DEATH      | MONTH       | DAY YEAR                                 | 2b. HOUR                           |
| nay be<br>page 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |               |                                                                          | MARY                              |                      | ELIZABETH                                   |              | TRAI          | Ĺ                    | DEC                  | EMBER         | 26          | 1985                                     | 2 AM                               |
| E . 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 3. SE         |                                                                          |                                   | 4. RACE              | 10-11-0                                     | S. DATE C    | F BIRTH       | YEAR                 | 6. AGE (IN           | YEARS LAST BI | RTHOAY}     | MONTHS DAYS                              |                                    |
| Page 4<br>director<br>hours off                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | PEMALE                                                                   |                                   | WHIT                 |                                             | MAY          | 11            | 1910                 | 75                   |               | YRS.        |                                          |                                    |
| ath. Po                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |               | RTHPLACE (STATE C                                                        | OR FOREIGN                        |                      | WHAT COUNTRY?                               | 8.<br>MARRIE | NEVER         | MARRIED -            | 1                    |               | OR COUNT    | Y OF DEATH                               |                                    |
| 9 5 5 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 10.0          | PA.                                                                      | FATI                              |                      | S.A.                                        | WIDOWE       |               | ONORCED              |                      | EGANY         | 10.1        | No. topso-                               | 06 0110 11 1500                    |
| ē 93 Æ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | /             | ITY OR TOWN OF D                                                         |                                   | (IF NOT IN SU        | HOSPITAL, NURSING CHEACILITY, GIVE STREET   | ADDRESS)     | K OTHER IN    | SHIUIKON             |                      | OCCUPAT       |             |                                          | OF BUSINESS                        |
| in by the filled                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |               | AL RESIDENCE (IF NO                                                      |                                   | AT HOM               |                                             |              |               | C-1/001              | <b>IHOUSE</b>        | WIFE          |             |                                          |                                    |
| 4 ho                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 13a.          | STATE                                                                    | 136 COUN                          | ITY                  | 13c. CITY OR TOV                            | /N           |               | CITY LIMITS?         | 13e. STREE           |               |             | 7.07                                     | 60                                 |
| should be a should |               | ARYLAND<br>ATHER'S NAME                                                  | ALLE                              | <i>J</i> ANY         | LITTLE C                                    | RLEAN        |               | NO LX                | RFD:                 |               |             | 0 - 1                                    |                                    |
| 15/1/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1             | CECIL                                                                    |                                   | MIDDLE               | LAST                                        | כוייוני      |               | FIRST                |                      | MIDDLE        |             |                                          | AST                                |
| at a second                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 160.          | VAS DECEASED EVI                                                         | R IN U.S. AR                      | U. MED FORCES?       | SCHRI<br>1166 SOCIAL SECT                   |              | 17. INFORM    | SSCELLA              |                      | ADDR          | ESS         | _HILL_                                   |                                    |
| 30                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |               | YES, NO OR UNKNOWN)                                                      | (IF YES, GIV                      | E WAR OR DATES)      | 218-60-1                                    | 022          | DADIII        | TRAIL :              | ם מאיייי             | בוחדו ז       | ויו דאווי   |                                          | m 01E0                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               |                                                                          | TM /Fater as                      |                      | r line far (o), (b), ar                     |              | DANTE         | TVAIL                | STAK K               | OUIE          | FLIMI       |                                          | XIMATE INTERVAL<br>LONSET AND DE   |
| THE CO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               | PART I. DEATH                                                            | WAS CAUSE                         | D BY:<br>E CAUSE (a) | CARRO                                       |              | 1014          | NY                   | ALRZ                 | ST            | 0.1         |                                          |                                    |
| quires that the de<br>signed by the in-<br>hen please remon<br>to burial, crementa<br>njury, or athe Hou                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | NO            | Canditians, if ar<br>gave rise to in<br>cause (a), sta<br>underlying cau | mmediate<br>ting the<br>ise last. | (c)_                 | OR AS A CONSEOU                             |              | NOT RELATE    | D TO THE TERM        | INAL DISEA           | SE OR COM     | ADITION G   | IVEN IN PART I                           | la:                                |
| on. hos been permit. I ene prior                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | CERTIFICATION | 190 DATE OF OPER                                                         | NOITA                             | 196 CONE             | DITION FOR WHICH                            | OPERATION    | N WAS PERF    | ORMED                | 200 AU               | OPSY?         | IN CERT     | ES, WERE FIND<br>TIFYING CAUSE<br>YES [] | INGS USED                          |
| IYSICIAN: The Icaling physician. Is certificate has burial-transit per Mental Hygiene.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               | 21g. ACCIDENT WAS ON CONTRIBUTING                                        | CAUSE OF DEA                      | TH HOUR A            | OF INJURY<br>A.M. MONTH D                   | AY YEAR      | 21c. HOW I    | NJURY OCCUR          | RED (ENTER )         |               |             |                                          |                                    |
| DING PHYS or ottendin After this e as the bu olith and Me                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | MEDICAL       | WHILE NOT AT WORK                                                        | WHILE VORK                        |                      | OF INJURY<br>TREET, FACTORY, OFFICE,        | FARM, ETC.)  | 21f LOCAT     |                      |                      | CITY OR TO    | OWN         | COUNTY                                   | STAT                               |
| TTEN<br>TOR.<br>for us<br>of He                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | saw the dece                                                             | ased alive an                     | n. 6. 4              | he deceased fram_<br>19_6<br>y after death. | , an         | d that in (m) | y) (aur) apinian     | , ta<br>death accurr |               | late and ho | our and fram the                         | , that (I) (we)<br>e causes states |
| TAL OR by the hore RAL DIRE edetaches state Dep                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | 226 PHYSICIAN'S                                                          | etian                             | 1.                   | Haven                                       | 1            | M P           |                      | MEDICA<br>DIRECTO    | STA           | CIAN        | 122c. DAT                                | = SIGNED                           |
| TO HOSPITAL retained by th TO FUNERAL should be det with the State IMPORTANT:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |               | DR. ROE                                                                  | BUSTIAN                           | 10 J. BA             | ARRERA                                      |              | MEMOR         | IAL HOSI             |                      |               | AL BU       | ILDING                                   | CUMBER                             |
| BP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |               | BURIAL, CREMATION BURIA                                                  |                                   | DEC29,               |                                             |              |               | CREMATORY<br>EMETERY | PINE                 | Y OR TOWN     |             | LLEGAN                                   |                                    |
| DHMH - 16 50M 4/B2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |               | UNERAL DIRECTOR                                                          |                                   |                      | ADDRESS                                     |              |               | DEC                  | E REC'D. BY          | REGISTRAR     |             | STRAR'S SIGNA                            | TURE                               |
| (VRA 15, 4)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 5             | SILCOX-MET                                                               | RITTF                             | UNERAL               |                                             | BERLAN       | D MARY        | TANHEL               | 301                  | 100 A         | paro        | evidour-A                                |                                    |

UEUSO EN JUMBER POR

|                                                                          | - 5                                                                                                                                                                             | 57                                                                                                                    |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|
|                                                                          | HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate by executed with 24 hospitals as the nest of the continued by the heaptful as attending physician. | FUNERAL DIRECTOR After this centralists has been signed by the offending physician and component interior by the time |
| -                                                                        | 1                                                                                                                                                                               | 3                                                                                                                     |
| 20                                                                       | -                                                                                                                                                                               | 150                                                                                                                   |
| 5                                                                        | 13                                                                                                                                                                              | M.                                                                                                                    |
| 0                                                                        | 1 2                                                                                                                                                                             | Д                                                                                                                     |
| A                                                                        | 1.                                                                                                                                                                              |                                                                                                                       |
| ¥                                                                        | 1                                                                                                                                                                               | 30                                                                                                                    |
| × ×                                                                      | 1                                                                                                                                                                               | 3                                                                                                                     |
| 2                                                                        | - 3                                                                                                                                                                             | 1                                                                                                                     |
| ui"                                                                      | - 3                                                                                                                                                                             | 35                                                                                                                    |
| Ö                                                                        | 1                                                                                                                                                                               | T                                                                                                                     |
| Σ                                                                        | - 1                                                                                                                                                                             | 2.6                                                                                                                   |
| 5                                                                        | 0                                                                                                                                                                               | -5 5                                                                                                                  |
| 8                                                                        | to:                                                                                                                                                                             | 15 K                                                                                                                  |
| 1                                                                        | 1                                                                                                                                                                               | 4                                                                                                                     |
| DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201 | e Ce                                                                                                                                                                            | 0                                                                                                                     |
| ō                                                                        | £                                                                                                                                                                               | · p                                                                                                                   |
| SI                                                                       | 0                                                                                                                                                                               | He                                                                                                                    |
| OC .                                                                     | 0                                                                                                                                                                               | 0                                                                                                                     |
| -                                                                        | ÷                                                                                                                                                                               | 4                                                                                                                     |
| 3                                                                        | 10                                                                                                                                                                              | by                                                                                                                    |
| 0                                                                        | +                                                                                                                                                                               | 70                                                                                                                    |
|                                                                          | 0                                                                                                                                                                               | gue                                                                                                                   |
| 0                                                                        | 5                                                                                                                                                                               | 25 4                                                                                                                  |
| ő                                                                        | 5                                                                                                                                                                               | ee.                                                                                                                   |
| <u>n</u>                                                                 | 3                                                                                                                                                                               | P                                                                                                                     |
| ~                                                                        | e =                                                                                                                                                                             | has                                                                                                                   |
| 4                                                                        | F 05                                                                                                                                                                            | 0 1                                                                                                                   |
| 5                                                                        | 2.2                                                                                                                                                                             | 0                                                                                                                     |
| 4                                                                        | 5 0                                                                                                                                                                             | 李子                                                                                                                    |
| z                                                                        | 2 2                                                                                                                                                                             | 8                                                                                                                     |
| 0                                                                        | £ 2                                                                                                                                                                             | 15-                                                                                                                   |
| 2                                                                        | 1,2                                                                                                                                                                             |                                                                                                                       |
| 6                                                                        | 7.0                                                                                                                                                                             | 51                                                                                                                    |
|                                                                          | 90                                                                                                                                                                              |                                                                                                                       |
|                                                                          | 23                                                                                                                                                                              | Ö                                                                                                                     |
| 4                                                                        | A 9                                                                                                                                                                             | 52.3                                                                                                                  |
|                                                                          | HOSPITAL OR ATTENDING PHYSHCIAN. The Limited by the hexpetal or attending physician.                                                                                            | #                                                                                                                     |
| -                                                                        | 0 9                                                                                                                                                                             | 0                                                                                                                     |
|                                                                          | 4                                                                                                                                                                               | 4                                                                                                                     |
|                                                                          | 9.0                                                                                                                                                                             | 4                                                                                                                     |
|                                                                          | 0.6                                                                                                                                                                             | 5                                                                                                                     |
|                                                                          | T 5                                                                                                                                                                             | 46.                                                                                                                   |

| 07096                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |               | REGISTRAR                                              |                              |                          |              | CATE OF DEATH              |          | REG. N                                                                |              |                   |                                    |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|--------------------------------------------------------|------------------------------|--------------------------|--------------|----------------------------|----------|-----------------------------------------------------------------------|--------------|-------------------|------------------------------------|--|
| 10 00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |               | CEASED NAME FIRST OLIV                                 | e J                          | ane                      | TT           | vigg                       | 20       | DATE OF DEATH                                                         | 12           | 29 85             | 9:15 P                             |  |
| 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 3. SE         | X                                                      | 4 RACE                       |                          | 5. DATE OF   | BIRTH YEAR                 | 6        | AGE (IN YEARS LAST B                                                  | RTHDAY)      | MONTHS DAYS       |                                    |  |
| \$ 00 h/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |               | 'emale                                                 | White                        |                          | Jan.         |                            |          | 93                                                                    | YRS          | MONTHS            | HOURS MIN.                         |  |
| 4 50 %                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               | IRTHPLACE (STATE OR FOREIGN<br>COUNTRY)                | 76 CITIZEN OF                | WHAT COUNTRY?            | 8<br>MARRIED | ☐ NEVER MARRIED            | 9        | BALTIMORE CITY                                                        | OR COUNT     | Y OF DEATH        |                                    |  |
| 1 19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |               | ITY OR TOWN OF DEATH                                   | USA                          | HOCDITAL MILIDGIA        | WIDOWED      | DIVORCED OTHER INSTITUTION |          | Allega:                                                               | ny           |                   |                                    |  |
| 主题(事/)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1             |                                                        | (IF NOT IN SU                | CH FACILITY, GIVE STREET | ADDRESS)     |                            | - 1      | 128 USUAL OCCUPATION 1749E OF WORK FOR MOST OF WORKING LIFE! INDUSTRY |              |                   |                                    |  |
| 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | USU           | Imberland AL RESIDENCE IF NURSING HOME                 | OR OTHER INSTITUTION         | GIVE RESIDENCE BEFORE    | ADMISSION)   | sing Home                  |          | lousewif                                                              | = -          | Own               | Home                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | STATE 136 CO                                           | egany                        | Corrig                   |              | 13d INSIDE CITY LIMIT:     | S?  13   | Rt. # 1                                                               | / ZIP CODI   |                   |                                    |  |
| 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 14. F         | ATHER'S NAME                                           | WIDDLE                       | LAST                     |              | S MOTHER'S MAIDEN          | NAME     | WIDDLE                                                                | - 614        |                   | AST                                |  |
| 1 11/10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 0             | harles                                                 | MIDDLE                       | Aller                    |              | Flore                      | ence     | A.                                                                    |              |                   | sidy                               |  |
| de gen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               | WAS DECEASED EVER IN U.S., YES NO OR UNKNOWN) (IF YES. | ARMED FORCES?                | 16b. SOCIAL SECU         |              | 17 INFORMANT               |          | ADDR                                                                  |              |                   |                                    |  |
| 3 50 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | No            |                                                        |                              | 212-74-                  |              | Gwendolyr                  | Mc Mc    | Cray, B                                                               | altim        |                   |                                    |  |
| hysic<br>pape<br>oval.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               | 18 CAUSE OF DEATH (Enter<br>PART I. DEATH WAS CAU      | anly one cause pe<br>SED BY: | r line far (a), (b), and | d Icial      | vcandia                    | 0        | Til                                                                   | 0-           | BETWEEN           | XIMATE INTERVAL<br>ONSET AND DEATH |  |
| certifing prints |               | IMMED                                                  | ATE CAUSE (a)                | Marke                    |              | · in a contract of         |          | angu                                                                  | chin         |                   |                                    |  |
| Hend<br>Hend<br>on, o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |               | Canditians, if any, which                              | DUE TO, C                    | DRAS A CONSEQUE          | 1/           | votice Co                  | and      | in volse                                                              | ula          |                   |                                    |  |
| the de of the de of the de of the of  |               | gave rise to immediate cause (a, stating the           | DUE TO C                     | OR AS A CONSEQUE         |              |                            | 0 == 0   | diseas                                                                | 0            |                   |                                    |  |
| by the sale of the |               | underlying cause last.                                 | (6)                          | JK AS A CONSECTOR        | INCE OF      |                            |          | 00-100-2                                                              |              |                   |                                    |  |
| igned<br>en ple<br>buric<br>Jry, a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 7             | PART 2 OTHER SIGNIFICAN                                | CONDITIONS                   | ONTRIBUTING TO           | DEATH BUT N  | OT RELATED TO THE          | TERMINA  | AL DISEASE ORICON                                                     | UDITIONGI    | EN IN PART I      | la .                               |  |
| require to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | TIO           | UPPLU CT.                                              |                              | DITION FOR WHICH         | , Ver        | it n'and a                 | $\vee$   | 1,migo                                                                | 0            | - Webs con        | h100                               |  |
| n. ne pr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | CERTIFICATION | 146 DATE OF OPERATION                                  | 198 CONL                     | SITION FOR WAIGH         | OPERATION    | WAS PERFORMED              |          | 200 AUTOPSY?                                                          | IN CERTI     | _                 | S OF DEATH?                        |  |
| sicia<br>ate t<br>ansit<br>ygie<br>8 sha                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | EE            | 21a. ACCIDENT WAS UNDERLYING                           |                              |                          |              | 21¢ HOW INJURY OC          | CURRED   | YES NO                                                                |              | PART L OR PART 2) | NO [                               |  |
| 34 441                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               | OR CONTRIBUTING CAUSE OF I                             |                              | .M. MONTH DA             | YEAR         |                            |          |                                                                       |              |                   |                                    |  |
| d April 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | MEDICAL       | 21d. INJURY OCCURRED                                   | 21e. PLACE                   | OF INJURY                |              | 21f LOCATION               |          | CITY OR T                                                             | OWN          | COUNTY            | STATE                              |  |
| Se state                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 2             | AT WORK NOT WHILE                                      | (AI HOME 3)                  | REET, PACTORY, OFFICE P  | ARM EIC)     |                            |          |                                                                       |              |                   |                                    |  |
| A A A S E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |               | 220.1 certify that (1) (this has                       |                              | he deceased from _       |              | , , ,                      | *3_      | , to 12 -                                                             | 29           |                   | , that (I) (we) las                |  |
| ATTE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |               | sow the deceased alive above, (I) (we) (did) (did      | nat view the bady            | after death.             |              | that in (my) (our) opi     | nian dea | th accurred an the a                                                  | date and hau |                   |                                    |  |
| A MANAGE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |               | 226 SIGNATURE                                          | Le                           |                          | D            | EGREE ATTENDIN             | IG /     | MEDICAL _ STA                                                         | AFF          |                   | -30-85                             |  |
| HOSPITAL<br>med by t<br>FUNERAL<br>Ad by der<br>the Stoke                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | -             | 224 PHYSICIAN'S NAME TIPE                              | OR PRINT)                    | •                        |              | PHYSICIA<br>22e ADDRESS    | N D      | IRECTOR A PHYSI                                                       | CIAN []      | 10-               | -30-05                             |  |
| O HOS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | П             | V. A. Ranjit                                           | han. M.                      | D.                       |              | L.M.N.H                    | . Se     | ton Drive                                                             | . Cumb       | erland            | . MD 215                           |  |
| 01 5313                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 23a           | BURIAL, CREMATION, REMOVA                              |                              |                          | AME OF CE    | METERY OR CREMATO          |          | 23d LOCATION                                                          |              |                   |                                    |  |
| BP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |               | (SPECIFY)                                              |                              | 1986 5                   | unset        | Memoria                    | 1 0      | Cumbe                                                                 | rland        | Alle              | STATE  Tany ME                     |  |
| DHMH - 16 60M 7/B4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |               | UNERAL DIRECTOR                                        |                              | Cumberl                  |              | 25a.                       | DATER    | C'D. BY REGISTRA                                                      |              |                   |                                    |  |

STATE OF MARYLAND

Female Unite Jan. 9, 1892 93

ND USA Lion's Manor Nursing Home Housevife Own Home

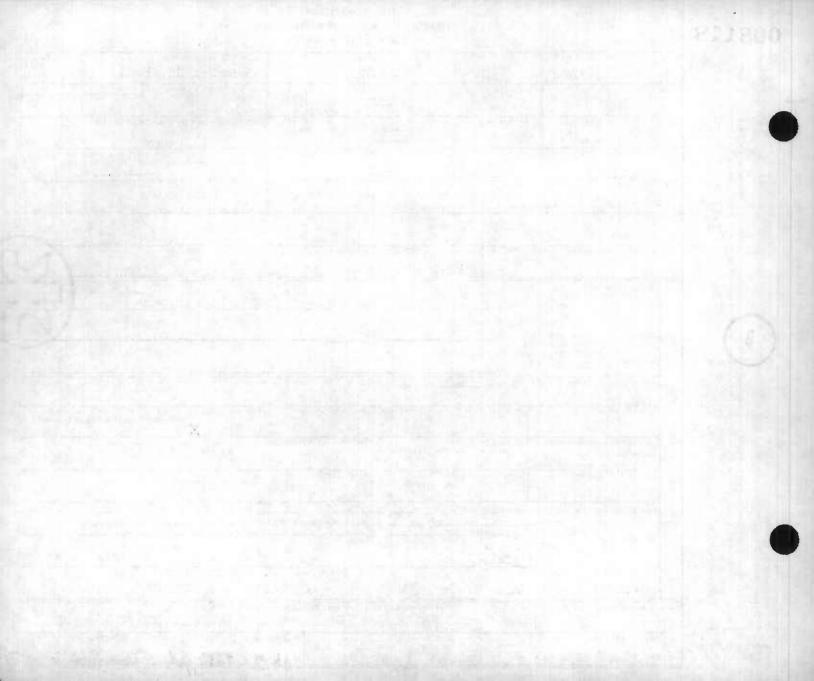
ND Allegany Corriganville x Nt. # 1, 21524

Charles Allen Plorence A. Cassidy

lo Gwendolyn NcCray, Daltimore, ND

Durial Jan. 2, 1986 Sunset Lemorial P. Cumberland Allegany ED william G. Kight Cumberland, ED

| Silcox .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |               | FOR                                |               |                      | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 3 2 8 6 |            |                                   |                                                       |                       |                                               |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|------------------------------------|---------------|----------------------|-----------------------------------------------------------------------|------------|-----------------------------------|-------------------------------------------------------|-----------------------|-----------------------------------------------|--|--|--|
| 008118                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1.            | - STATE<br>REGISTRAR               |               |                      | ori Anni                                                              |            | ICATE OF DEATH                    | REG. N                                                | 10.                   | 14                                            |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | CEASED NAME                        | FIRST         |                      | MIDDLE                                                                |            | AST                               | 2a. DATE OF DEATH                                     | MONTH DAY Y           | 2h HOUR10:02                                  |  |  |  |
| may be<br>poge 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ,             | CONTRINT)                          | KATE          |                      |                                                                       | VA         | NCE                               | December                                              | 28, 1985              | P. M                                          |  |  |  |
| mo mo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 3. SE         |                                    |               | 4. RACE              |                                                                       | 5. DATE (  | DAY YEAR                          | 6 AGE IN YEARS LAST BE                                |                       | DATS HOURS MIN.                               |  |  |  |
| J ed os o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |               | FEMALE                             |               | WHI                  |                                                                       | JAN        | 9 1902                            | 83                                                    | YRS.                  |                                               |  |  |  |
| ter death. Per within 72 hours of the death.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |               | COUNTRY) W. VA                     | DR FOREIGN    | USA                  | WHAT COUNTRY?                                                         | WIDOW      | D NEVER MARRIED                   | 9 BALTIMORE CITY 9                                    | egany_                | MD.                                           |  |  |  |
| - 0 +0 -/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |               | Cumber1                            | and           | (IF NOT IN SUC       | norial Ho                                                             | spita      | POTHER INSTITUTION                | 120 USUAL OCCUPAT<br>(TYPE OF WORK FOR MOST<br>HOUSEW | OF WORKING LIFE) INDU | IND OF BUSINESS OR                            |  |  |  |
| 4 hour led in ld be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 13a S         | STATE                              | 113h COUI     | VIY                  | GIVE RESIDENCE BEFORE                                                 | ADMISSION) | 13d INSIDE CITY LIMITS?           | 13e.STREET ADDRESS                                    | / ZIP CODE            |                                               |  |  |  |
| LAND 24 h min 24 h tilled should I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |               | RYLAND                             | ALL           | EGANY                | FLINTSTO                                                              | ONE        | YES NO 💢                          | RFD#1 BOX                                             |                       | 530                                           |  |  |  |
| within within                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 14. FA        | JOHN                               |               | WIDDLE               | LAST                                                                  |            | 15. MOTHER'S MAIDEN NA            | ME                                                    |                       | LAST                                          |  |  |  |
| MAR comple                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |               |                                    | ED INLLIC AF  | LUED FORCECO         | DAY                                                                   | DITT.      | MYRA                              | ADDR                                                  | BRICKE                | R                                             |  |  |  |
| DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 2120 NG PHYSICIAN. The law requires thin the distributions be executed within 24 hours offending physician.  The house certificate has been signed in the different physician and completely filled in by as the buriol-transit permit. Then please to propers. Pages 1 and 2 should be file than and Mental Hygene prior to buriol cremitation of mimoval.  The property of the property of other manufactures, the medical exeminer may be factored at them 18 shows any injury, or other manufactures, the medical exeminer may be factored.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |               | WAS DECEASED EV                    |               | /E WAR OR DATES)     | 120 TO 3 THE                                                          | THEIGH     | 17. INFORMANT<br>EVELINE COLLI    |                                                       |                       | MARYLAND                                      |  |  |  |
| BALI<br>sate l<br>spers<br>vol.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | 18 CAUSE OF DE                     | ATH Enter of  | nly one cause per    | line for (o), (b), on                                                 | d ich      | 1 1                               | 1 1                                                   |                       | APPROXIMATE INTERVAL<br>TWEEN ONSET AND DEATH |  |  |  |
| ST.,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |               | PARTI. DEATH                       |               | TE CAUSE (a)         | my                                                                    | OC         | andlest .                         | bulan                                                 | cleon                 |                                               |  |  |  |
| Z                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |               |                                    |               | DUE TO, O            | R AS A CONSEQUE                                                       | NCE OF     | .10                               | V                                                     |                       |                                               |  |  |  |
| B ( B B t )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |               | Canditians, if a                   |               | (b)                  | #3                                                                    |            | VI                                |                                                       |                       |                                               |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | cause (0), sta<br>underlying cau   | ting the      | DUE TO, O            | R AS A CONSEQUE                                                       | NCE OF     |                                   |                                                       |                       |                                               |  |  |  |
| 201<br>rip plea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               |                                    |               | (c)                  | ON CHILDRICH CO.                                                      | OF ATH BUT | NOT BELATED TO THE TERM           | IN ALL DISCASE OR COL                                 | IDITION CAPELLAND     |                                               |  |  |  |
| Then to bu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | NO            | PART 2 OTHER ST                    | GNIFICANT     | LONDITIONS <u>CC</u> | DAIRIBUTING TO L                                                      | JEATH BUT  | NOT RELATED TO THE TERM           | INAL DISEASE OR COR                                   | IDITION GIVEN IN PA   | ART 1(a                                       |  |  |  |
| nos beer no permit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | CERTIFICATION | 19a DATE OF OPER                   | RATION        | 19b. COND            | ITION FOR WHICH                                                       | OPERATIO   | N WAS PERFORMED                   | 200 AUTOPSY?                                          | 20b. IF YES, WERE F   | AUSES OF DEATH?                               |  |  |  |
| N. The landstream visition. The landstream visition. It has shown to have the stands of the landstream visition.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ERT           | 21a ACCIDENT WAS                   | INDERLYING T  | 7 21b. TIME O        | F INJURY                                                              |            | 21¢ HOW INJURY OCCUR              | YES NO X                                              | YES                   | NO []                                         |  |  |  |
| SICIAN- ng physical prior prio |               | OR CONTRIBUTING                    | CAUSE OF DE   | HOUR A.              |                                                                       | YEAR       |                                   |                                                       |                       |                                               |  |  |  |
| PHYSK<br>ending<br>this ce<br>the burid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | MEDICAL       | 21d INJURY OCCU                    |               | 21e PLACE            | OF INJURY                                                             |            | 211 LOCATION                      |                                                       |                       |                                               |  |  |  |
| DING Property After the e os the although morked to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ¥             | WHILE NOT                          | WHILE         | (AT HOME STE         | REET FACTORY OFFICE F                                                 | ARM ETC )  | STREET                            | OT RO YTI)                                            | OWN COUN              | NTY STATE                                     |  |  |  |
| NDIN<br>If ar aft<br>R: Aft<br>Vise oil                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |               | 220 I certify that                 |               | ital) attended th    | e deceased from_                                                      | 12         | 124 19 82                         | 10 (2                                                 | 128,198-              | that (I) (we) last                            |  |  |  |
| m 2 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |               | sow the dece                       | ased alive on | The body             | atter death                                                           | 3.60       | nd that in (my) (aur) apinion (   | death occurred an the o                               | ate and haur and fra  | m the couses stated                           |  |  |  |
| he he her                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 100           | 27h SKSNATURE                      | . 10          | . 1                  | aner deam                                                             |            | DEGREE                            | /                                                     |                       | DATE SIGNED                                   |  |  |  |
| 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |               | 1                                  | 18            | Xd                   | -                                                                     |            | ATTENDING<br>PHYSICIAN            | MEDICAL STA                                           |                       | 2/29/85                                       |  |  |  |
| HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |               | 224 PHYSICIAN'S                    | NAME (TYPE    | OR PRINT)            |                                                                       | 1.00       | 22e. ADDRESS 441 N                |                                                       |                       |                                               |  |  |  |
| 0 0 0 5 0 /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |               | Dr. Wil                            | liam P        | . Iames              |                                                                       |            | Cumbe                             | rland, MD                                             | 21502                 |                                               |  |  |  |
| ρ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 23a. 8        | BURIAL, CREMATIO<br>(SPECIFY) BURI |               | 31 DEC               |                                                                       |            | EMETERY OR CREMATORY CHRISTIAN CE | 23d LOCATION<br>MT INGLESM                            | TH BEDFORI            | D PENNA TATE                                  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 24 FI         | UNERAL DIRECTOR                    |               |                      |                                                                       | 7          | 25a. DAT                          | E REC'D. BY REGISTRAR                                 | 25b. REGISTRAR'S SIG  | GNATURE                                       |  |  |  |
| DHMH - 16 60M 7/84<br>(VRA 15, 4)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |               | STI COX_ME                         | יוייד קק      | TA CHIMIT            | ADDRESS CEDVICE                                                       | CT IMDIS   | RLAND MARY                        | M 4000                                                | di Krida              | March 182- "                                  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | TITAL TITAL                        |               | T. CHALLINAL         |                                                                       | COMBR      | T HIND MAKIN AND                  |                                                       |                       |                                               |  |  |  |



page 3

campletely filled in by the funeral director, page 3

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

## FOR STATE

#### STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

| 8    | 3      |       | 3   | 2    | Ğ   | 3    | 4 |
|------|--------|-------|-----|------|-----|------|---|
|      | REG. N | 10.   |     | 15   |     | 300  | W |
| OF D | EATH   | HINOM | DAY | YEAR | 2 b | HOUR |   |

|   | REGIST                     | KAK                         |                |                    |                   | 4                  |                 |                 | REC                  | 3. NO.            |                                 |                                    |     |
|---|----------------------------|-----------------------------|----------------|--------------------|-------------------|--------------------|-----------------|-----------------|----------------------|-------------------|---------------------------------|------------------------------------|-----|
|   | 1 DECEASED I               | VAME                        | FIRST          | 1                  | AIDDLE            |                    | AST             |                 | 20 DATE OF DEAT      | нгиом Н           | DAY YEAR                        | 2b. HOUR                           | П   |
|   | (TATE ON THE VI)           | EI                          | DNA            |                    | JANE              |                    | WALTERS         | 3               | December             | r 21, 1           | 1985                            | 7:10a                              | • ^ |
|   | 3. SEX                     |                             |                | 1. RACE            |                   | 5. DATE C          | OF BIRTH        | WE AD           | 6. AGE (IN YEARS LAS | T BIRTHDAY)       | MONTHS DAYS                     |                                    |     |
|   | FE                         | MALE                        |                | WHITE              | 5                 | JAN                | UARY 1,         | 1915            | 70                   | YRS               |                                 | HOURS M                            | 14. |
|   | 7a BIRTHPLAC               |                             | OREIGN         | b CITIZEN OF       |                   | TRY? 8             | D NEVER         | MARRIED         | 9 BALTIMORE CIT      | Y OR COUNT        | TY OF DEATH                     |                                    |     |
|   |                            | YLAND                       |                | U.S                |                   | WIDOWE             | D D             | VORCED          | ALLEGA               | NY                |                                 |                                    | ME  |
| 7 | 10 CITY OR TO              | OWN OF DEA                  | тн             |                    | HOSPITAL, NU      | JRSING HOME (      | OR OTHER INS    | TITUTION        | 17a USUAL OCCUI      |                   |                                 | OF BUSINESS C                      | )R  |
|   | Cumber                     |                             |                |                    |                   | & MEDI             | CAL CEN         | TER             | CLERK                |                   | GROC                            | ERY                                |     |
| V | 13a STATE                  |                             | 136 COUN       | TY                 | 136 CITY OR       | BEFORE ADMISSION)  | 13d. INSIDE C   | ITY LIMITS?     | 13e SIRFFI ADDRE     | SS./ ZIP CO       | DE-                             | POV 100                            | 1   |
|   | MARYL                      |                             | ALLE           | GANY               | MT. SA            | AVAGE              | YES 🟝           | NO 🗌            | 13. FOUNDRY          | ROW,              | 21545 (                         | BOX 423                            | )   |
|   |                            | IRST                        | A              | NIDDLE             | LAS1              |                    |                 | S MAIDEN NA     | 4400                 | LE                |                                 | AST                                |     |
| 1 | -                          | ILLIAM                      | 1              |                    | RIFFIT            |                    |                 | ATHERIN         |                      |                   | HARTI                           | G                                  |     |
|   | 160 WAS DEC<br>(YES, NO OR |                             |                | WAR OR DATES)      |                   | SECURITY NO.       | 17 INFORMA      |                 |                      | DDRESS            | Section S                       |                                    |     |
|   | NO                         |                             |                |                    | 216-22            | 2-6692             | CHARL           | ES E. W         | ALTERS, S            | AME AS            |                                 |                                    |     |
|   | 18 CAU                     | SE OF DEATH                 | H (Enter onl   | y one couse per    | line for to 1, 16 | o, and ic          | ( A             |                 |                      |                   | BETWEEN                         | XIMATE INTERVAL<br>NONSET AND DEAT | н   |
|   |                            |                             |                | CAUSE (o)          | lepi              | matan              | aller           | 2               |                      |                   |                                 |                                    |     |
|   | 1100                       |                             |                | DUE TO, Q          | AS A CONS         | EQUENCE OF         |                 | 7               |                      |                   |                                 |                                    |     |
| 2 |                            | ions, if ony,               |                | (b)_               | mon               | c Obsh             | uctive          | Jung            | Theore               |                   |                                 |                                    |     |
|   | couse                      | rise to imm<br>(0), stoting | g the          | DUE TO, OI         | RAS A PONS        | QUENCE OF          |                 | 0               |                      |                   |                                 |                                    |     |
|   | underly                    | ring couse                  | lost.          | (c)                | 1                 | a                  |                 |                 |                      |                   |                                 |                                    |     |
|   | PART 2                     | OTHER SIGN                  | IFICANT C      | ONDITIONS CO       | ONTRIBUTING       | TO DEATH BUT       | NOT RELATED     | TO THE TERM     | INAL DISEASE OR C    | ONDITION G        | IVEN IN PART 1                  | 10                                 |     |
|   | Sig. ACC                   | E OF OPERAT                 | VA             | 101 601101         | ,                 |                    | 111111 C 05050  |                 | Ter with the service | Tan 15 M          | FC 14/FBF 51/19                 |                                    |     |
|   | S IND DAT                  | E OF OPERAL                 | A              | 196 CONDI          | TION FOR WI       | HICH OPERATIO      | N WAS PERFO     | RMED            | 20a AUTOPSY?         |                   | ES, WERE FINDI<br>TIFYING CAUSE |                                    |     |
| _ | 21- 400                    | IDENT WAS UND               | 19             | 216 TIME O         | E INTRIDV         | 16.                | Tale HOW IN     | LIURY OCCUPE    | YES NO               |                   | YES 🗌                           | NO 🗌                               | _   |
|   | 00.0011                    | RIBUTING TO                 | AUSE OF DEAT   |                    |                   | DAY YEAR           | ZICHOWIN        | NOCCORN         | ED (ENTER NATURE OF  | INJURY IN ITEM 18 | J PART ( ORPART 2)              |                                    |     |
|   | (IF EITH                   | ER NOTIFY MEDIC             | AL EXAMINER)   | P. PLACE (         |                   | 19                 | 211 LOCATIO     | N N             | 1                    |                   |                                 |                                    | _   |
|   | AAMILE                     | MOT NOT                     | JA             | (AT HOME, STR      | EET, FACTORY OF   | FF E FAM ETC)      | STREET          | NI              | A CITY C             | ORTOWN            | COUNTY                          | STATE                              |     |
|   | AT WORK                    | AT WOR                      | CA LANGE AND A | -1) - 44 4 - 4 - 4 | - da 1 (          | - 17               | 22105           | - (             |                      |                   |                                 |                                    |     |
|   | sow                        | the decease                 | d alive        | ol) offeeded the   | n                 |                    | nd that in (mv) | (our) opinion o | deoth accurred on th | e date and he     |                                 | , that (1) (we) li                 | ost |
|   |                            | Ve. () (we) (d              | lid) (did not  | view the body      | after death       |                    | DEGREE          |                 |                      |                   |                                 | E SIGNED                           |     |
|   | X                          | Mo                          | 10-8           | 2                  |                   |                    | ,               | ATTENDING       | MEDICAL S            | STAFF             | (2                              | 121/16                             |     |
| - | 22d PHY                    | SICIAN'S NA                 | ME (TYPE OR    | PRINT)             |                   |                    |                 |                 | DIRECTOR PH          |                   | 110                             | 104/07                             | -   |
|   | Dr.                        | James                       | Rave           | r                  |                   |                    |                 |                 | spital Med           | iical E           | sidg.                           |                                    |     |
| - | 23a BURIAL, C              | REMATION                    | REMOVAL        | 23b. DATE          |                   | 23c. NAME OF C     |                 |                 | MD 21502             |                   |                                 |                                    | _   |
|   | (SPECIFY)                  |                             | KEMIOVAL       | DEC.2              |                   | Autoria Territoria |                 |                 | CITY OF TOW          | VACE              | COUNTY                          | STATE                              |     |
|   | В                          | URIAL                       |                | 1 100.2            | 2,00              | METHOD:            | LST CEM         | ETERY           | LIT . DH             | . VACE,           | ALLEGAN                         | Y. MD.                             |     |

BP

TO HOSPITAL

should be detached for use as the burial-transit permit. Then please remove it with the State Dept. of Health and Mental Hygiene prior ta burial, cremation

torked or Item

IMPORTANT: If them 21 is

After this certificate has been

TO FUNERAL DIRECTOR.

TENDING PHYSICIAN: The

njury, ar ather tro

DHMH - 16 60M 7/84 (VRA 15, 4)

DURST FUNERAL HOME.

24 FUNERAL DIRECTOR

NAME

MT. SAVAGE, ALLEGANY, MD

254 REGISTRAR'S SIGNATURE

FROSTBURG, MD. 21532 LEC

The state and the state is also itel at the state and

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 2120

FOR STATE

#### STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

|   | REGISTRAR                                                      |                                                                                                                                                                                                                               | CERTIFI            | CATE OF DEATH                  | REG. N                                                           | 0.                                    |              |                                  |
|---|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|--------------------------------|------------------------------------------------------------------|---------------------------------------|--------------|----------------------------------|
|   | I. DECEASED NAME FIRST (TYPE OR PRINT) MABE                    | L MARGIE                                                                                                                                                                                                                      |                    | ATKINS                         | December 1                                                       | MONTH DAY                             | YEAR         | 7:50 <sub>P.M</sub>              |
|   | 3. SEX female                                                  | 4 RACE<br>White                                                                                                                                                                                                               | 5. DATE O          | F BIRTH<br>5-22-1899***        | 6. AGE (IN YEARS LAST BIR                                        | YRS                                   | UNDER I YEAR | IF UNDER 24 HRS                  |
| 7 | 70. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD                   | 76. CITIZEN OF WHAT COUNTRY  USa                                                                                                                                                                                              | MARRIED<br>WIDOWEI | NEVER MARRIED D                | 9 BALTIMORE CITY O<br>Allegany                                   | R COUNTY OF                           | FDEATH       | MD                               |
| p | © CITY OR TOWN OF DEATH  Cumberland                            | 11. NAME OF HOSPITAL, NURSI<br>(IF NOT IN SUCH FACILITY, GIVE STREE<br>Memorial Hospit                                                                                                                                        | tal                | R OTHER INSTITUTION            | 170 USUAL OCCUPATION OF WORK FOR MOST OF WORK FOR MOST OF MOUSEW |                                       | INDUSTRY     | home                             |
| , | JSUAL RESIDENCE LIF NURSING HOME OF 130 STATE MD               | egany Cumber                                                                                                                                                                                                                  |                    | 13d INSIDE CITY LIMITS? YES NO | 13e STREET ADDRESS                                               | van Ave                               | nue/2]       | L502                             |
| 1 | 14 FATHER'S NAME FIRST  James                                  | R. Stump                                                                                                                                                                                                                      |                    | 15. MOTHER'S MAIDEN NAM        | na Belle Ro                                                      | bey                                   | t AS         |                                  |
|   | 160. WAS DECEASED EVER IN U.S. A (YES NO OR UNKNOWN) (IF YES G | RMED FORCES? 166 SOCIAL SEC 219-14-                                                                                                                                                                                           |                    | Mr. Robert S                   | ADDRE<br>S. Watkins,                                             |                                       | land,        | MD - sc                          |
|   | PART 1. DEATH WAS CAUS                                         | DUE TO, OR AS A CONSEQUENCE OF T | Brice of           | morely gottet                  | gestete                                                          |                                       | APPROXI      | MATE INTERVAL<br>ONSET AND DEATH |
|   |                                                                | CONDITIONS CONTRIBUTING TO                                                                                                                                                                                                    | DEATH BUT          | NO RELATED TO THE TERM         | NAL DISEASE OR CON                                               | DITION GIVEN                          | IN PART 1:0  |                                  |
| _ | The DATE OF OPERATION 2                                        | 18. CONDITION FOR WHICH                                                                                                                                                                                                       | H OPERATION        | N WAS PERFORMED                | 20s. AUTOPSYP                                                    | IM IF YES, W<br>IN CERTIFYIN<br>YES [ | IG CAUSES    |                                  |
|   | OR CONTRIBUTING CAUSE OF OR                                    | HOUR A.M. MONTH [                                                                                                                                                                                                             | DAY YEAR           | 21c. HOW INJURY OCCURR         | RED (ENIER NATURE OF INJUI                                       | RY IN ITEM 18 PART                    | I OR PART 2) |                                  |
|   | AT WORK AT WORK                                                | 21e PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE                                                                                                                                                                       |                    | 211 LOCATION<br>STREET         | CITY OR TO                                                       |                                       | COUNTY       | STATE                            |
|   | saw the deceased alive a                                       | oital) attended the deceased from  12 - /1 19  at) view the bady after death.                                                                                                                                                 |                    | d that in (my)(aur) apinian o  |                                                                  |                                       |              | than (we) last<br>causes stated  |
|   | 224 SICNIATITUE                                                | 0.                                                                                                                                                                                                                            | 0                  | DEGREE                         |                                                                  |                                       | 22c. DATE    | SIGNED                           |

224 PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Terry Williams

for a William

77e ADDRESS

Hillcrest Burial

ATTENDING MEDICAL STAFF
PHYSICIAN DIRECTOR PHYSICIAN Memorial Hospital Medical Bldg.

12-12-85

STATE

230. BURIAL, CREMATION, REMOVAL

23c. NAME OF CEMETERY OR CREMATORY

Cumberland, MD 21502

Burial 24 FUNERAL DIRECTOR

James F. Scarpelli, Cumberland, MD 21502

12-14-1985

23b. DATE

Park Cumberland

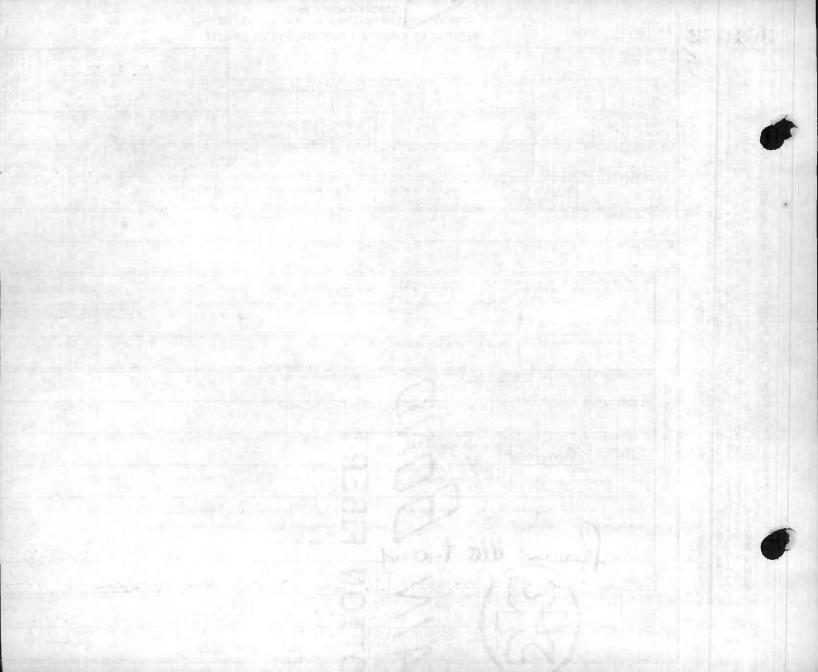
AR 256. REGISTRAR'S SIGNATURE

DHMH - 16 60M 7/B4 (VRA 15, 4)

| /                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | Shaffers F                                          | uneral Home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STAT                | E OF MARYLAND                 | 0 -                          | 7 0                                           | 8 6                                    |
|---------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------|------------------------------|-----------------------------------------------|----------------------------------------|
| 7                         | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1             | FOR STATE 230 E. Mai                                | n Street DEI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     | IEALTH AND MENTAL HYG         | SIENE O O                    | 0 6                                           | , , ,                                  |
| 1                         | 20000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |               | REGISTRAR Romney,                                   | WV 26757                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | CERTIF              | ICATE OF DEATH                | REG. NO                      | ).                                            |                                        |
|                           | 013099                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               | CEASED NAME FIRST                                   | MIDDLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1000                | LAST                          | 20. DATE OF DEATH            |                                               | 2b. HOUR                               |
|                           | e c c pe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (ITPE         | Max                                                 | Eugene                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Wave                |                               | December 3                   | 1. 1985                                       | 3.40A M                                |
|                           | a d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 3. SE)        |                                                     | 4 RACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 5. DATE O           |                               | 6. AGE (IN YEARS LAST BIRT   | HDAY) IF UNDER 1 YEA                          |                                        |
| 1                         | ge 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |               | Male                                                | White                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Aug                 | 4 6 4 4 4 4 4                 | 57                           | YRS.                                          | S HOURS MIN.                           |
| 5                         | Pog<br>dire                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |               | RTHPLACE   STATE OF FOREIGN                         | 76. CITIZEN OF WHAT COUL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | VTRY? 8.            | M verse v vente [             | 9. BALTIMORE CITY O          | R COUNTY OF DEATH                             |                                        |
|                           | n 72 n 72                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |               | idiana                                              | U.S.A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | WIDOWI              | DIVORCED                      | Allegany                     | County                                        | MD                                     |
|                           | er d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 10 CI         | TY OR TOWN OF DEATH                                 | 11. NAME OF HOSPITAL, N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | IURSING HOME        |                               | 120 USUAL OCCUPATION         | ON 12b. KIND                                  | OF BUSINESS OR                         |
| 5                         | the set the se | Cun           | berland                                             | Sacred Hear                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                     | -a1                           | Service Mai                  | WORKING LIFE) INDUSTR                         | . Navy                                 |
| 212                       | in the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | USU           | AL RESIDENCE (IF NURSING HOME TATE 13b. CO          | OR OTHER INSTITUTION, GIVE RESIDENC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | E BEFORE ADMISSION) |                               |                              |                                               | 00000                                  |
| N                         | Filled Sould                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 130. 3        |                                                     | pshire Romne                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     | 13d. INSIDE CITY LIMITS?      | P. O. Box                    | 339                                           | 77777                                  |
| YLA                       | rely to she she iner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 14. F.A       | THER'S NAME                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     | 15. MOTHER'S MAIDEN NA        | ME                           |                                               |                                        |
| MARYLAND 2120             | m be ond                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |               | Silas                                               | Waye LA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ST                  | FIRST                         | he Marie                     | Waye                                          | LAST                                   |
| ORE,                      | nd co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |               |                                                     | ARMED FORCES? 166. SOCIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | L SECURITY NO.      | 17. INFORMANT                 | ADDRE                        | SS D DD                                       | 26757                                  |
| LIMO                      | Po o o                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               | les Wor                                             | Id War 131024                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 8519                | Constance K                   | . Way P. O                   | . Box 339,                                    | Romney, WV                             |
| BALTIMORE                 | a, the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               | 18. CAUSE OF DEATH (Enter<br>PART I. DEATH WAS CAUS | only one couse per line for a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (b), and (c)        |                               | Comme                        |                                               | OXIMATE INTERVAL<br>IN ONSET AND DEATH |
| ST.,                      | / pan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |               |                                                     | ATE CAUSE (o)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Ltast               | etce live                     | Clucer                       | 0                                             | Molatha                                |
| PRESTON ST                | ( Bath) of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1.0           |                                                     | DUE TO, OR AS A CON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | SEQUENCE OF         |                               |                              |                                               |                                        |
| EST                       | Voi no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               | Conditions, if any, which                           | (b)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |                               | <u> </u>                     |                                               |                                        |
| . P.                      | 2 211                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |               | gove rise to immediate cause (a), stating the       | DUE TO, OR AS A CON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | SEQUENCE OF         |                               |                              |                                               |                                        |
| 2                         | that<br>d by<br>ease<br>al, c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |               | underlying couse lost.                              | (c)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |                               |                              |                                               |                                        |
| 5, 2(                     | uires<br>igne<br>en pl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | z             | PART 2. OTHER SIGNIFICAN                            | T CONDITIONS CONTRIBUTIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | G TO DEATH BUT      | NOT RELATED TO THE TERM       | VINAL DISEASE OR CONE        | ITION GIVEN IN PART                           | J.o.                                   |
| DIVISION OF VITAL RECORDS | requestre transfer to the control of | CERTIFICATION | 19a DATE OF OPERATION                               | 196. CONDITION FOR V                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ALUCII OPERATIO     | ALL LANGE OF THE COLUMN       | Top AUTODOVO                 | Ton 45 MEG. 1445DS 50 46                      |                                        |
| REC                       | low low son sermine prince of son                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | FICA          | IVE DATE OF OPERATION                               | 196. CONDITION FOR V                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | VHICH OPERATIO      | IN WAS PERFORMED              | 20a AUTOPSY?                 | 206. IF YES, WERE FIND<br>IN CERTIFYING CAUSE | ES OF DEATH?                           |
| TAL                       | The ricion sit p                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | RTI           | 21g. ACCIDENT WAS UNDERLYING                        | 21b. TIME OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     | 131. HOW MILLIPY OCCUP        | YES NO X                     | YES [                                         | NO []                                  |
| N N                       | physicial physic |               | OR CONTRIBUTING CAUSE OF E                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | H DAY YEAR          | 21c. HOW INJURY OCCUR         | KED [ENTER NATURE OF INJUR   | Y IN ITEM 18 PART I OR PART 2                 | )                                      |
| 0                         | SICI ng L                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | WEDICAL       | (IF EITHER, NOTIFY MEDICAL EXAMIN                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 19                  |                               |                              |                                               |                                        |
| Sio                       | PHY<br>this<br>the bund w                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | MED           | 21d. INJURY OCCURRED                                | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | OFFICE, FARM ETC )  | 211. LOCATION<br>STREET       | CITY OR TO                   | WN COUNTY                                     | STATE                                  |
| >iq                       | NG<br>After<br>os t<br>orke                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |               | AT WORK                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     | \$ 19 00                      | 12                           | 131 00                                        |                                        |
|                           | S S S S S S S S S S S S S S S S S S S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |               | 22a. Lettify that (1) (this has                     | pital) of enged the deceased                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6.1                 | 19 03                         | , to                         | 19 00                                         | ., that (1) (we) last                  |
|                           | ATT<br>DSplit<br>ECTC<br>d fo<br>d fo<br>m 21                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |               | apave (t) [we] [did] (did)                          | not) were the body after pleath.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                     | nd that in (my) (our) opinion | accurred on the do           |                                               |                                        |
|                           | OR DIRE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |               | 274 SECHASORE                                       | Munt                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ALA                 | DEGREE                        | MEDICAL STAF                 |                                               | TE SIGNED                              |
|                           | PITAL by th IERAL oe deto Store ANT: I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               | 100                                                 | off may                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | VILLE               | PHYSICIAN                     | DIRECTOR PHYSIC              | IAN [ 12/                                     | ′31/85                                 |
|                           | OSPI<br>ed b<br>d be<br>she S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |               | 274 PHYSICIAN'S NAME ITH                            | Section Control of the Control of th |                     | 22e ADDRESS                   |                              |                                               | 0 Seton Dr                             |
|                           | TO HOSPITAL<br>retained by the TO FUNEAL Should be det with the State IMPORTANT:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |               | Richard Schm                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     | Dept Of Pulm                  |                              | ine, SHH, Cu                                  | mberland md                            |
|                           | F 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |               | URIAL, CREMATION, REMOVA                            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 23t. NAME OF C      | EMETERY OR CREMATORY          | 23d LOCATION<br>CITY OR TOWN | COUNTY                                        | STATE                                  |
| 99                        | 99BPC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | C             | remation                                            | 1/1/86                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Omps Cr             | remation Servi                |                              |                                               |                                        |
| 11                        | DHMH - 16 50M 4/83                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 24. Ft        | INERAL DIRECTOR Keith                               | S. Shaffer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | DRESS               | 250 DAT                       | N 7 1986                     |                                               |                                        |
|                           | (VRA 15, 4)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |               | Sharrer Fune                                        | eral Home, Romi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ney, WV             | On                            | 1 1000                       | Archia Davidson                               | n-Handale                              |

King the state of Techniques remail femals in Santas Lab HER partition virginities to presi Fire of the state of the state

|   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       | OR                              |                                      |            |                | DEPART        |                 |             | MARYLAN<br>H AND MI |               | YGIEN     | È S         |              | 3 2            | 2 0 2        | 3 /               |
|---|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|---------------------------------|--------------------------------------|------------|----------------|---------------|-----------------|-------------|---------------------|---------------|-----------|-------------|--------------|----------------|--------------|-------------------|
|   | 361022                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                       | TATE<br>EGISTRAR                |                                      |            | ME             | DICAL         | EXAMI           | NER'S       | CERTIFIC            | CATEC         | F DEA     | TH          | REG          | NO.            |              |                   |
|   | /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                       | EASED NAME                      | FIRST                                |            |                | WIDDLE        |                 |             | LAST                |               |           |             | KNOWN        |                | H DAY YE     | AR 24 HOU         |
|   | 2 × 8 8 2 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | TYPE                  | OR PRINT)                       | ESTELI                               | LA         |                | A.            |                 | WE          | EBB                 |               | 100       | OF<br>DEATH | ESTI-        | XX 12          | 2-21-85      | 1                 |
|   | PEA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 3. SEX                |                                 | 1. RACE                              | 5. DAT     | E OF BIRTH     | YEAR          | 6. AGE (IN Y    |             | NDER 1 YR.          | IF UNDER      |           | 2c. DAT     |              | MONTH          | DAY Y        | AR 2d. HOU        |
|   | DELAY IS NECESSARY, PLEASE DID 37 OTHE FUNREAL DIRECTOR. ETAIN PAGE 5 FOR YOUR FILES. ALID BE FILED, WITHIN 72 HOURS. CORDS, 201 W. PRESTON STREET,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                       | male                            | White                                | Fe         | b. 10          | ,1896         | 89              | rrs.        | DAYS                | HOURS         | MIN       | DEA         | D            |                | 21-8519      | 8:00              |
| 4 | ESS ESS ALL Y ALL  |                       | THPLACE (STA                    | ATE OR                               | 7b. CIT    | IZEN OF W      | VHAT COUN     | VTRY?           | 8 MARI      | RIED NE             | VER MARR      | ED 🗆      | 9. BALTIA   | MORE CIT     | Y OR COU       | NTY OF DEATI | 1                 |
|   | S S S S S S S S S S S S S S S S S S S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | We                    | st Virg                         | ginia                                |            | S.A.           |               |                 |             | WED 🔽               | DIVORC        | ED 🗆      | A11         | egan         | (TYPE OF WOR   |              | JM.               |
|   | SEED SEED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 10 CIT                | Y OR TOWN C                     | OF DEATH                             | 11. N.A    | NOT IN SUCH F  | SPITAL, NU    | TREET ADDRESS   | E, OR OT    | HER INSTITU         | TION          | FOR A     | MOST OF WO  | PRKING LIFE) |                | OR IND       | BUSINESS<br>JSTRY |
|   | APA BY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                       | mberlar                         |                                      |            | 2              | Utah 1        | Avenue          |             |                     |               | Tee       | acher       | -Nic         | holas          | Co. Bd       | of Ed             |
|   | ORENA S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | USUAL<br>13a ST       |                                 | IF IN HURSING HOME                   | YTY        | INSTITUTION, C |               | OR TOWN         | iON)        | 13d. INSIDE C       | ITY EIMITS?   | 13e. STRI | EET ADDR    | RESS         |                |              |                   |
|   | 표 중축위한편                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                       | ryland                          | Alle                                 | gany       |                | Cuml          | berlan          | d           | YES X               | NO 🗆          |           |             | 1 Ave        | nue /          | 21502        |                   |
|   | M H 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 14. FA1               | THER'S NAME                     |                                      | MIDDLE     | E              |               | LAST            |             | 15. MOTHE           | ER'S MAIDE    | NAME      |             | MIDDLE       |                | LAST         |                   |
|   | ME PAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                       | Cottle                          |                                      | В          |                |               | yer             |             | Sa                  | rah           |           |             | -            |                | Hamon        |                   |
|   | TIMOR<br>FORM<br>FORM<br>CONO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 16a W<br>(YES         | AS DECEASED<br>S, NO, OR UNKNOV | EVER IN U.S. AR                      |            |                | 1000          | CIAL SECURI     |             | 17. INFOR           | THAM          |           |             | ADDR         | RESS           |              |                   |
|   | BALTI<br>GNE<br>WITH R<br>WITH R<br>DIVISIO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                       |                                 |                                      |            |                | 217           | -10-53          | 91D         | Aubre               | ey We         | bb -      | Addr        | ess          | same a         | s #13 a      | above.            |
|   | T. W. W. D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       | 18 CAUSE OF                     | DEATH (Enter or                      | nly ane co | ause per lin   |               |                 | OT 1        | TATIT               |               |           | 100         |              |                |              | MATE INTERVAL     |
|   | N THESE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 10                    | PARTIDEA                        | IMMEDIA                              | TE CAUS    |                | CARC          |                 | OF J        | JAW                 |               | HA        |             |              |                |              |                   |
|   | PREESO<br>THIN 2<br>THER ALL<br>ALL HYG<br>REMOV                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                       |                                 |                                      |            | DUE TO, O      | R AS A COI    | NSEQUENCE       | OF          |                     |               |           |             |              |                |              |                   |
|   | E E SE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                       | gave rise                       | s, if any, which<br>e ta immediate   | e /        | (b)            | 4.6           |                 |             |                     |               |           |             |              |                |              |                   |
|   | NA NA NA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                       | lying caus                      | stating the <u>under</u><br>se last. |            | DUE TO, O      | R AS A COI    | NSEQUENCE       | OF          |                     |               |           |             |              |                |              |                   |
|   | S PANAGO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                       |                                 |                                      | (-         | (c)            |               |                 |             |                     |               |           |             |              |                |              |                   |
|   | CERTIFICATE SHOULD BE EXCUTED TING THE WORD "PENDING IN 17 THE WORD "PENDING IN 18 SHOULD BE USED AS A BUILD DEPARTMENT OF HEALTH AND IN PRIOR TO BURIAL, CREMATION IN PRIOR TO BURIAL, CREMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                       | PART 2 OTHER SIG                | NIFICANT CONDITIONS                  | CONTRIBU   | TING TO DEAT   | H BUT NOT REL | ATEO TO THE TER | MINAL OISEA | ISE OR CONDITIO     | N GIVEN IN PA | RT 1 (a)  |             |              |                |              |                   |
|   | MECO BE WED BE WED BE WED AS A HEALTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ATK                   | 19a DATE OF                     | OPERATION                            |            | 19b COND       | ITION FOR     | WHICH OPE       | RATION      | WAS PERFOR          | MED?          |           |             |              |                | 20 AUTO      | PSY?              |
|   | FUITAL RE WORD "PE CHIEF A BE CHIEF A BE USED SINTOF HE BURIAL,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | IFIC I                |                                 |                                      |            |                |               |                 |             |                     |               |           |             |              |                | YES          | NO EX             |
|   | W HE CHANGE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | H H                   |                                 | L CAUSE WAS                          |            | 21b. TIME C    |               | DAY VE          | 21c. +      | HOW INJURY          | OCCURRE       | D (ENTER  | NATURE OF I | NJURY IN ITE | M 18 PART 1 OR |              |                   |
|   | S CERTIFICATE SH<br>RITING THE WOR<br>ROED TO THE CP.<br>RE 3 SHOULD BE U.<br>OF PROPERTOR OF THE CP.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | MEDICAL CERTIFICATION | UNDERLYING                      | U OR<br>IG □ CAUSE OF                | DEATH      | P./            |               | DAY YEA         | AR .        |                     |               |           |             |              |                |              |                   |
|   | /ISIG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ă                     | 214 INJURY O                    |                                      |            |                | OF INJURY     |                 | 211. LC     | OCATION             |               |           | CITY OR TO  | 21.01        | 1016           |              | STATE             |
|   | DIVIS  JATE, WRITIN  CARE, WRITIN  FORWARDED  OR: PAGE 3.5  HE STATE DEP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 2                     | AT WORK                         | NOT WHILE [                          |            | STREET, FA     | CTORT, FARM,  | erc.j           |             | STREET              |               |           | CITY OR TO  | JWN          |                | COUNTY       | SIAIE             |
|   | ME: TI<br>NTE,<br>DRW<br>PR: P.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       | 22a. I certif                   | y that I taak char                   | ge of the  | remains de     | escribed ob   | ave, held an    | Auta        | psy .               | Inspectia     | XX        | Inquiry     | KX.          | and in my      | noiniao      | 300               |
|   | EXAMINER:<br>CERTIFICATI<br>JUID BE FOR<br>UDIRECTOR:<br>A WITH THE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                       | death resulte                   | d ron. Natu                          | ral cause  | es XX          | Accident      | ☐. s            | vicide [    | ], Hamie            | cide .        |           | ermined m   |              | ].             |              |                   |
|   | ERTHE BIRE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                       |                                 | ()                                   |            | 84.0           | 1             |                 |             |                     | PECIFY)       |           |             |              |                |              |                   |
|   | A POPULATION AND A POPU |                       | ACTUAL<br>SIGNATURE_            | Vialu                                | ~          | LILO           | WT-           | Our             |             | M.D. Depu           |               | MED       | ICAL EXA    | MINER        | DAT            | E 12-2       | 1-85              |
|   | DEA STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                       |                                 | 1                                    | -          |                |               |                 |             |                     |               |           |             |              |                |              |                   |
|   | TO MEDICAL EXAMIN<br>EXECUT THE CERTIFIC<br>PAGE A SHOUD BY<br>TO FUNERAL DIRECT<br>AFTER DEATH, WITH THE<br>BALTIMORE, MARYLA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                       | (TYPE OR PRIN                   | NAME Giov                            | ranni      | L Mast         | range         | olo, M.         | D           | _ADDRESS            | 900 Se        | eton      | Drive       | e, Cr        | mberl          | and, Mo      | 2150              |
|   | 524548                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 23a. BU               | RIAL, CREMAT                    | ION, REMOVAL                         |            |                |               |                 | METERY      | OR CREMATO          | ORY           | 123d LC   | CATION      |              |                |              |                   |
|   | BP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                       | urial                           |                                      |            | 3-85           |               |                 |             | urial [             |               | Cun       | iber1       | and-         | Allega         | ny Co        | -Md.              |
|   | DHMH - 17                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                       |                                 | TOR George                           |            |                |               |                 | ome,        | p.A.                | DEU           | REC'D. BY |             | AR 25b. R    | EGISTRAR'S     | SIGNATURE    | 2                 |
|   | (VR A15 ME (5))                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 120:                  | 2 Green                         | e Stree                              | t-Cui      | mberl          | and,          | Md. 2           | 1502        |                     | DLO           | 92        | 1985        | U            |                |              | - 4               |



O FUNERAL DIRECTOR, After

DIVISION OF VITAL RECORDS, 201 W.

DHMH - 16 60M 7/B4 (VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| 1.            | FOR<br>STATE<br>REGISTRAR                                               |                                                             | DEPARTA                               |            | EALTH AND MENTAL HYG                   | REG. NO.                                   | U 6.                                        | , 0                               |
|---------------|-------------------------------------------------------------------------|-------------------------------------------------------------|---------------------------------------|------------|----------------------------------------|--------------------------------------------|---------------------------------------------|-----------------------------------|
|               | CEASED NAME                                                             | IR51                                                        | WIDDLE                                | i          | AST                                    | 20. DATE OF DEATH MONTH                    | DAY YEAR                                    | 26 HOUR                           |
| (1116         | R                                                                       | ANSOM                                                       | C                                     | WERT       | Z                                      | DECEMBER 8, 19                             | 985                                         | 12:00P                            |
| 3. SE         | X                                                                       | 4. RACE                                                     |                                       | 5. DATE C  |                                        | 6. AGE (IN YEARS LAST BIRTHDAY)            | IF UNDER 1 YEAR                             | IF UNDER 24 HRS                   |
|               | male                                                                    | whit                                                        | е                                     | MONTH      | 4-25-1906                              | 79 YR                                      | MONTHS DAYS                                 | HOURS MIN.                        |
|               | IRTHPLACE (STATE OR FOR                                                 | IGN 76 CITIZEN OF                                           | WHAT COUNTRY?                         | 8.         | D NEVER MARRIED                        | 9 BALTIMORE CITY OR COU                    |                                             |                                   |
|               | PA                                                                      | USA                                                         | 1                                     | WIDOWE     |                                        | Allegany                                   |                                             | M                                 |
| 10 C          | ITY OR TOWN OF DEATH                                                    |                                                             | HOSPITAL, NURSIN                      |            | OR OTHER INSTITUTION                   | 120 USUAL OCCUPATION                       |                                             | OF BUSINESS OF                    |
| CU            | MBERLAND                                                                |                                                             | AL HOSPIT                             |            |                                        | retired                                    |                                             | ktile                             |
|               | AL RESIDENCE (IF NURSING<br>STATE 13                                    | HOME OR OTHER INSTITUTION<br>L COUNTY<br>Allegany           | 134. CITY OR TOW<br>Cumber 1          | N          | 13d. INSIDE CITY LIMITS?<br>YES X NO . | 130 STREET ADDRESS / ZIP CO<br>307 Jeffers | ODE                                         |                                   |
| 14 F.         | ATHER'S NAME                                                            | MIDDLE                                                      | LAST                                  |            | 15 MOTHER'S MAIDEN NA                  | ME                                         | LAS                                         | ST                                |
|               | Valent                                                                  | ine Wertz                                                   |                                       |            | Arren                                  |                                            |                                             |                                   |
|               | WAS DECEASED EVER IN                                                    | U.S. ARMED FORCES?                                          | 166 SOCIAL SECU                       | RITY NO.   | 17 INFORMANT                           | ADDRESS                                    |                                             |                                   |
|               | no                                                                      |                                                             | 217-10-6                              | 555        | Mrs. Goldie N                          | 4. Lewis-Greens                            | pring, W                                    | <b>V</b>                          |
|               | 18 CAUSE OF DEATH I<br>PART I. DEATH WAS                                | Enter anly one couse per<br>CAUSED BY.<br>MEDIATE CAUSE (a) | r (ne far Ia), (b), and               | 0          | lespuato                               | y arrest                                   | APPROX<br>BETWEEN                           | IMATE INTERVAL<br>ONSET AND DEATH |
|               | Canditians, if any, w                                                   | hich ( b)_                                                  | SA DSL                                | S C        | tue to f                               | decimona                                   | i l                                         |                                   |
|               |                                                                         | the dist                                                    | DR AS A DOLLO                         | rcel       | ly UTI +                               | Cellulet                                   | 5                                           |                                   |
| NO            | PART OTHER SIGNIF                                                       | May 2                                                       | white                                 | DEATH BUT  | and Ch                                 | HOUSE AND THE                              | neg                                         |                                   |
| CERTIFICATION | 190 DATE OF OPERATIO                                                    | N 196 CONE                                                  | DITION FOR WHICH                      | OPERATIO   | N WAS PERFORMED                        | 200 AUTOPSY? 20b. IF<br>IN CE              | YES, WERE FINDI<br>RTIFYING CAUSES<br>YES [ | NGS USED<br>S OF DEATH?<br>NO     |
| _             | 210. ACCIDENT WAS UNDERLO OR CONTRIBUTING CAU (IF EITHER NOTIFY MEDICAL | SE OF DEATH HOUR A                                          |                                       | AY YEAR    | 21c. HOW INJURY OCCURE                 | RED (ENTER NATURE OF INJURY IN ITEM        | 18 PART I OR PART 2)                        |                                   |
| MEDICAL       | 21d INJURY OCCURRED                                                     |                                                             | OF INJURY<br>TREET FACTORY, OFFICE, F | ARM, ETC ) | 211 LOCATION<br>STREET                 | CITY OR TOWN                               | COUNTY                                      | STATE                             |
|               | 220.1 certify that (1) (th                                              | is haspital) attendedit                                     | he dedeased from                      | 12         | 18/1085                                | 10 12 8                                    | 10                                          | that (Mwe) las                    |

ATTENDING MEDICAL STAFF
PHYSICIAN DIRECTOR PHYSICIAN 226. PHYSICIAN'S NAME (TYPE OF PRINT) MEMORIAL HOSPITAL

MEDICAL BUILDING DR. NATHAN CUMBERLAND, MARYLAND 21502

DEGREE

23c. NAME OF CEMETERY OR CREMATORY 23a BURIAL, CREMATION, REMOVAL 23d LOCATION 236 DATE Chaneysville Burial 12-11-1985 Chaneysville Cemetery

24 FUNERAL DIRECTOR James F. Scarpelli, Cumberland, MD 21502

saw the deceased alive an abave, wi (we) (did) (did no

226. SIGNATURE

STATE

that in (hort (aur) apinian death accurred on the date and hour and from the causes stated

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 2120

#### STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

|    | I. DECEASED NAME                                                    | FIRST                  | ٨              | AIDDLE                                               | 1          | AST                      | 2a. DATE OF DEATH        | MONTH      | DAY       | YEAR                  | 2h HOU     | IR     |
|----|---------------------------------------------------------------------|------------------------|----------------|------------------------------------------------------|------------|--------------------------|--------------------------|------------|-----------|-----------------------|------------|--------|
|    | (TYPE OR PRINT)                                                     | LUCY                   | MA             | ARIE                                                 | WH         | ETZEL                    | December 7               | , 19       | 85        |                       | 4:0        | 0 pm   |
|    | 3. SEX                                                              |                        | 4. RACE        |                                                      | 5. DATE C  |                          | 6 AGE (IN YEARS LAST BIR | THDAY      |           | ERIYEAR               | IF UNDER   | 24 HRS |
| ij | female                                                              |                        | white          |                                                      | MONTH<br>O | 9-04-1913 YEAR           | 72                       | YRS.       | MONTHS    | DAYS                  | HOURS      | MIN.   |
| d  | To BIRTHPLACE (STATE                                                | OR FOREIGN             | 76 CITIZEN OF  | WHAT COUNTRY?                                        | 8.         | D NEVER MARRIED          | 9 BALTIMORE CITY         | R COUN     | TY OF DE  | ATH                   |            |        |
| d  | 70. BIRTHPLACE (STATE                                               |                        | USA            | <del>J</del>                                         | WIDOWE     |                          | Allegan                  | У          |           |                       |            | MD.    |
| À  | 10 CITY OR TOWN OF                                                  | DEATH                  |                | OSPITAL, NURSIN                                      |            | OR OTHER INSTITUTION     | 12a USUAL OCCUPAT        |            |           | KINDO                 | BUSINE     | SS OR  |
| 1  | Cumberland                                                          | l                      | (IF NOT IN SUC | Memo                                                 |            |                          | retired                  | IF WORKING |           | Tire                  | Co.        |        |
| 5  | USUAL RESIDENCE (IF N<br>130 STATE<br>MD                            | 13b COU                |                | GIVE RESIDENCE BEFORE<br>13t. CITY OR TOWI<br>CUMDET | ν .        | 13d. INSIDE CITY LIMITS? | 13e STREET ADDRESS       | / ZIP COI  | DE Sti    | reet                  | S.W        | ./215  |
| 1  | 14 FATHER'S NAME FIRST C                                            | yde A.                 | Ballow         | LAST                                                 |            | 15. MOTHER'S MAIDEN NAM  |                          |            |           | LAST                  |            |        |
|    | (YES, NO OR UNKNOWN)                                                |                        |                | 219-14-6                                             |            | Mr. John W. 1            | whetzel, Cu              |            | land      | , MD                  | <b>-</b> S | on     |
|    | 18 CAUSE OF DE<br>PART I. DEATH                                     | WAS CAUSE              |                | line far (a), (b), and                               |            | rulmmy a                 | ment                     |            | 8         | APPROXIM<br>BETWEEN O | MATE INTER | DEATH  |
|    | Conditions, if a<br>gove rise to<br>cause (a), ste<br>underlying ca | immediate<br>ating the | (b)            | AS A CONSEQUE                                        | NCE OF     |                          |                          |            |           | loy                   |            |        |
| 1  | PART 2. OTHER S                                                     | IGNIFICANT (           | MF;            | ONTRIBUTING TO D                                     | EATH BUT   | NOT RELATED TO THE TERM  | INAL DISEASE OR CON      |            | ES, WERE  |                       |            |        |
|    | THE DAIL OF OFF                                                     | NATIONA.               | 178 CONDI      | LIOIA LOK MALIICH                                    | OLFWALLO   | A AAMO LEKLOKWED         | THE MOTORST              | 200. 11    | ED, WYERE | FLINDIN               | US USE     | )      |

CERTIFICA

71a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH MEDICAL

216. TIME OF INJURY HOUR A.M.

MONTH DAY YEAR 21e PLACE OF INJURY

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) (AT HOME, STREET, FACTORY, OFFICE FARM, ETC.)

211 LOCATION

DEGREE

St. Marys Cemetery

CITY OR TOWN

COUNTY

IN CERTIFYING CAUSES OF DEATH?

and that in (my) (aur) apinian death accurred on the date and haur and from the causes stated 22c. DATE SIGNED

STATE

MD

22d PHYSICIAN'S NAME

saw the deceased alive on abave (we) (did) (did not

ATTENDING MEDICAL STAFF
PHYSICIAN DIRECTOR PHYSICIAN 22e. ADDRESS 955 Frederick St.

Dr. Bollino 230 BURIAL, CREMATION, REMOVAL

Burial

226. SIGNATURE

23c. NAME OF CEMETERY OR CREMATORY 23b DATE

Cumberland, MD 21502 23d LOCATION SITY OR TOWN

NO

Cumberland

DHMH - 16 60M 7/84 (VRA 15, 4)

BP.

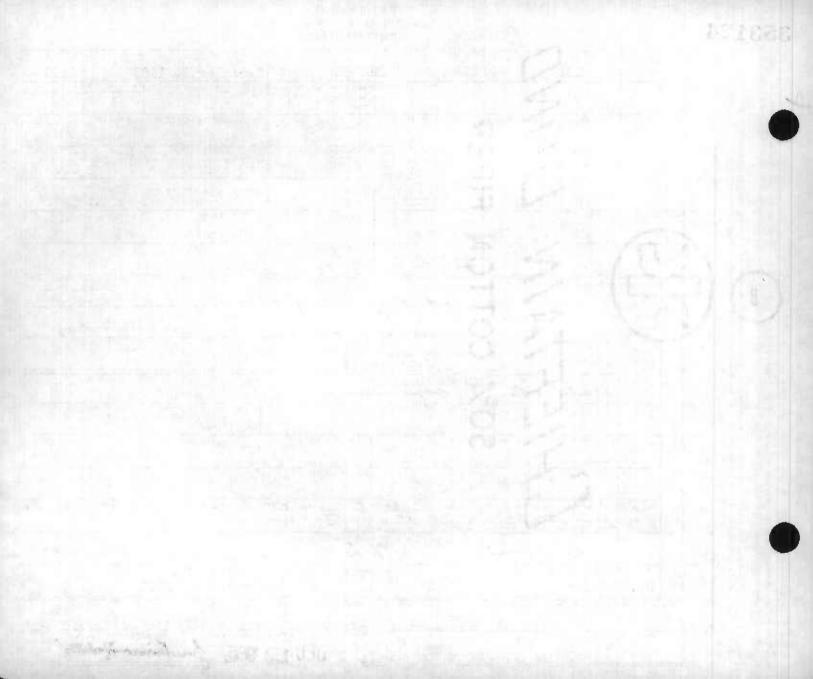
FUNERAL DIRECTOR

24 FUNERAL DIRECTOR

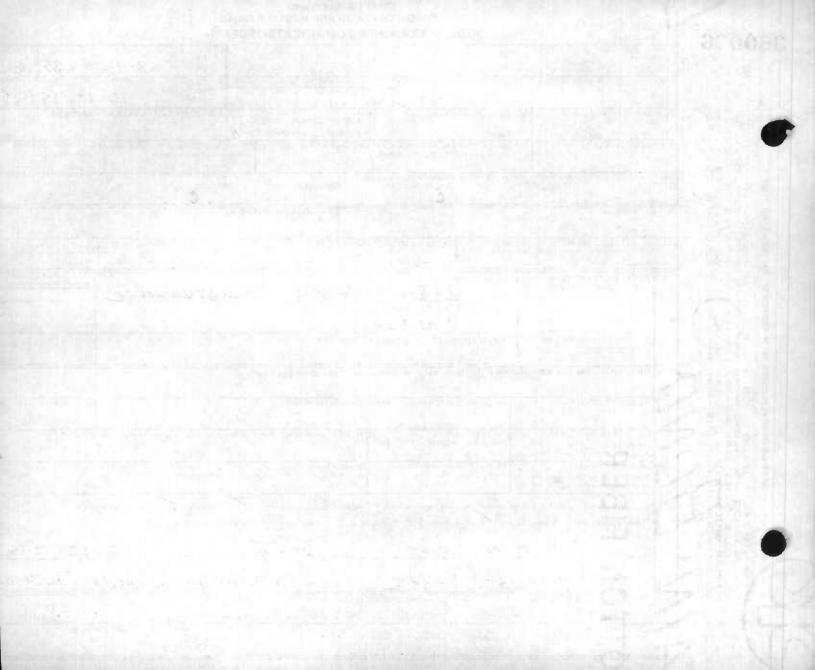
12-10-1985

22a I certify that N (this hospital) attended the deceased from

James F. Scarpelli, Cumberland, MD 21502



|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                          |                         |                        |                          | DEDA                |                    |              | AARYLAN             |                 | VOIENTE     | 100           | 3          | 2                                | 3        | 4       | U        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-------------------------|------------------------|--------------------------|---------------------|--------------------|--------------|---------------------|-----------------|-------------|---------------|------------|----------------------------------|----------|---------|----------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1 - ST                                                                                   | ATE                     |                        |                          |                     | EXAMIN             |              |                     |                 |             | <u> </u>      |            | Chine                            |          |         |          |
| 360026                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                          | GISTRAR<br>ASED NAME    | FIRST                  |                          | MIDDLE              |                    | IEK 3        | LAST                | CATEO           |             | DATE KN       | REG. NO    |                                  | DAY      | YEAR    | 2b. HOUR |
| 10.10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (TYPE O                                                                                  | R PRINT)                |                        |                          | F                   |                    | v 71         |                     |                 |             |               | STI-       |                                  | -        | 85      |          |
| 2 1 1 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 3 SEX                                                                                    | Be                      | RACE                   | S. DATE OF               |                     | 6. AGE (IN YE      |              | isler<br>NDER 1 YR. | IF UNDER 2      |             | DATE          | 7          | MONTH                            | DAY DAY  |         | 100 M    |
| ARY, REASE<br>DIRECTOR.<br>V72 HOURS<br>TON STREET.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                          |                         |                        | MONTH                    | DAY YEA             |                    |              | HS DAYS             |                 |             | DEAD          | D          | 12                               | 1210     | 85      | 1:1-8    |
| SAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Mal                                                                                      | HPLACE (STAT            | White                  | June 7h CITIZEN          | 25 192°             |                    | RS.          |                     |                 | _ 9 1       |               | ECITYC     | OR COUNT                         |          |         | , 12 W   |
| POSSESSA<br>FOR WOODS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | FOREI                                                                                    | GN COUNTRY)             |                        | USA                      |                     | OITIKI:            |              |                     | VER MARRIE      | DU          |               |            |                                  | . 01 524 |         |          |
| A San Sal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Pen<br>In CITY                                                                           | nsylvar<br>or fown or   | 11a<br>F DEATH         |                          |                     | NURSING HOM        | WIDOW        |                     | DIVORCE         | 12a. USUAL  | OCCUPAT       |            | SANY                             | 12b KIND | OF BUS  | MD.      |
| FERENCY (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 11                                                                                       |                         |                        | (IF NOT IN               | SUCH FACILITY, GR   | VE STREET ADDRESS) | 2, 011 011   | ien involvio        |                 | FOR MOS     | T OF WORKIN   | G LIFE)    | LI O                             | OR IN    | DUSTRY  | ,        |
| BO SHOW                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | USUAL                                                                                    | mberla<br>RESIDENCE (#  | and<br>In nursing home | Resi                     | dence               | NCE BEFORE ADMISS  | IONI         |                     |                 | STATI       | STIC          | IAN -      | - 0.51                           | GOV      | ERNI    | 1ENT     |
| PS SELANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 13a, STA                                                                                 | TE                      | 113b COUN              | VTY                      | 134, €              | ITY OR TOWN        | - '          | 13d. INSIDE C       |                 | 13e STREET  | ADDRESS       |            |                                  |          | 1 500   |          |
| 2 44 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                          | 502- MO                 | d. Alleg               | gany                     |                     | umberlan           | na           | YESXX               | NO 🔲            | 42/ N       | !! Cen        | tre        | Stree                            | t/2      | 150%    | )        |
| # E-895)//                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                          | FIRST                   |                        | MIDDLE                   |                     | LAST               |              | F                   | ER'S MAIDEN     | NAME        | MIDD          | LE .       | LAST                             |          |         |          |
| 8 88 8 W                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                          | SSEL                    | EVER IN U.S. AR        | MED FORCES               | 2 114h S            | ocial SECURIT      | YNO          | I III               | iise            | 1           | 71.01         | ADDRESS    | Hummel II.                       |          |         |          |
| BALTIMO<br>S AFTER<br>GIVE PA<br>ITH FOR<br>PAGES 1<br>WISION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                          | NO, OR UNKNOW!          |                        | WAR OR DATES)            |                     |                    |              |                     |                 | , 1         | /101          | Quee       | n Victoria et<br>Bourg, Maryland |          |         |          |
| S AFI<br>GIVE<br>MITH F<br>PAGE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | -   201-16-3285   Edna Whisler Gaithb                                                    |                         |                        |                          |                     |                    |              |                     |                 |             |               | bers       | burg,                            | Mary     | Z Lan   | d        |
| ST.<br>NO. S. C. C. S. C.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ľ                                                                                        | PART I DEAT             | TH WAS CAUSE           | nly one cause p<br>D BY: | per line far (a),   | (b), and (c).)     | 2010         | enti                | 0               | no dis      |               | 1.1        | 1                                | BETWEEN  | ONSET A | ND DEATH |
| NO THE SECOND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                          |                         | IMMEDIA                | TE CAUSE (a)             | O OPASAC            | ONSEQUENCE         |              | vory                |                 | orac (      | Jues          | ciex       | aj                               |          |         |          |
| <b>建☆</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                          | Canditians,             | if any, which          |                          | T                   | sease              |              |                     |                 |             |               |            |                                  |          |         |          |
| 36 5 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                          |                         | to immediate           |                          |                     | ONSEQUENCE         |              |                     |                 |             |               |            |                                  |          |         |          |
| 201 W. PRESTON ST<br>JFED WITHIN 24 HO<br>IN PROCI I PREM 11<br>EAST MANER ALGNO<br>ING TRANSI PREM<br>ON USE REMONAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                          | lying cause             |                        |                          | 10, OR A3 A C       | ONSLOOLINGE        | Or           |                     |                 |             |               |            |                                  |          |         |          |
| NAME E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 9                                                                                        | (c)                     |                        |                          |                     |                    |              |                     |                 |             |               |            |                                  |          |         |          |
| RECORDS,<br>DD BE DEC<br>PENDING<br>PENDING<br>PENDING<br>PENDING<br>PENDING<br>CREMATIR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                          |                         |                        | CONTRIGORNIO II          | O OLAIN BOT NOT     | CERTED TO THE TERM | NIUWE DISENS | E OR CONDINO        | U GIVEN IN PARI | 1 (0).      |               |            |                                  |          |         |          |
| AL RECO!  DUID BE DO!  "PEND!  FE HEALT!  AL. CRE.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | CERTIFICATION                                                                            | 9a. DATE OF O           | PERATION               | 19b. C                   | ONDITION FO         | OR WHICH OPER      | RATION W     | AS PERFOR           | MED?            |             |               |            |                                  | 20 AUT   | OPSY?   |          |
| N OF VITAL R CATE SHOUL HE WORD "P THE CHIEF UND BE USED JAMENT OF HE ET O BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | SF.                                                                                      |                         |                        |                          |                     |                    |              |                     |                 |             |               |            |                                  | YES      |         | NO 🗆     |
| F VI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                        | 10. EXTERNAL            | CAUSE WAS              |                          | IME OF INJUR        |                    | 21c. H       | OW INJURY           | OCCURRED        | (ENTER NATE | URE OF INJURY | IN ITEM 18 | PART 1 OR PAR                    |          |         | NOL      |
| DIVISION OF VITAL S CERTIFICATE SHOUJ RITING THE WORD " ROED TO THE CHIEF AS 3 SHOULD BE USE E DEPARYMENT OF H ED FROOF TO BURLAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                          | NDERLYING               | OR CAUSE OF            | HOL                      | JR A.M. MON<br>P.M. | TH DAY YEA         | R            |                     |                 |             |               |            |                                  |          |         |          |
| DIVISION HIS CERTIFIC WRITING TH ARDED TO ARGE 3 SHOU ATTE 03 SHOU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                          | INJURY OC               |                        | 21e P                    | LACE OF INJU        | RY (AT HOME,       |              | CATION              |                 |             |               |            | 1645                             |          |         |          |
| DIV<br>THIS CE<br>WARDE<br>WARDE<br>PAGE 3<br>STATE DI<br>212015                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ¥ \                                                                                      | T WORK                  | NOT WHILE              | STR                      | EET, FACTORY, FAR   | M, ETC.)           |              | STREET              |                 | C           | ITY OR TOWN   |            | COU                              | INTY     |         | STATE    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | F                                                                                        |                         |                        | 1                        |                     |                    |              |                     | 100             | T           |               |            |                                  |          |         |          |
| E CERTIFICATE, DULUD BE FORVAULD BE FORVAULD BE WITH HE SI H. WITH THE SI H. WARYLAND;                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                          |                         | that I taak char       | L.                       | 2                   |                    | Autop        |                     | Inspection      |             | Inquiry L     |            | nd in my api                     | inion    |         |          |
| EXAMI<br>GERTIFI<br>JID BE<br>DIRECT<br>WITH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                          | death resulted          | fram: Natu             | ral causes L             | , Accide            | nt L, Su           | vicide       | , Hami              |                 | Undeterm    | nined mann    | er 🔲,      |                                  |          |         |          |
| A WAY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | A                                                                                        | CTUAL                   | Draw                   | uniar                    | o Veu               | 4                  |              | TITLE               | PECIFY)         | -           |               |            | DATE                             | 17       | 17      | -0=      |
| SE S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 5                                                                                        | KGNATURE                | 1.100                  |                          | py                  |                    |              | 1.D                 | fully           | MEDICA      | L EXAMIN      | ER         | SIGNED                           | 012      | -/ <    | · 87     |
| COUTE AND THE PROPERTY OF THE | E                                                                                        | XAMINER'S N             | AME Fra                | neise                    | a Ro                | 405                |              | 1000500             | 900 5           | oton        | Dr.           | Com        | horl                             | and      | 111:    | 2150     |
| TO MEDICAL EXA<br>EXECUTE THE CERT<br>PAGE 4 SHOULD B<br>TO FUNERAL DIRE<br>BATTER DEATH, WIT<br>BALTIMORE, MARY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 23a BUR                                                                                  | IAL CREMATIC            | -                      | 23h DATE                 | [2                  | NAME OF CE         | METERY       | ADDRESS_            |                 |             | TION          | Jun        | 10011                            | K D(D    | 7-04    |          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 230. BURIAL, CREMATION, REMOVAL 236 DATE 236. NAME OF CEMETERY OF CREM. Rosedale Funeral |                         |                        |                          |                     |                    |              |                     |                 |             |               |            |                                  |          |         |          |
| BP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 24 FUN                                                                                   | MATION<br>IERAL DIRECTO | OB- C                  |                          |                     |                    |              |                     | 250. DATE RE    |             | GISTRAR       |            | ISTRAR'S 66                      | BIRATURE | ng are  | 1        |
| DHMH - 17<br>(VR A15 ME (5))                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                          | AME .                   | George                 | -upenur                  | Abskilss F UN       | MY J.              | 1502         | •17.                | חבו             | 0.23        | 1985          | - 14       | Denne ton                        |          |         |          |
| 7044 4/92                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1                                                                                        | / Green                 | Street                 | in mi                    | perland             | , Ma. 2.           | 1702         |                     |                 | 0 - 0       | .00           | U          |                                  |          |         |          |



|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               |                                                            | itt funeral Hon                                                                      |                | OF MARYLAND                | 2                         | 7 2                   | 3 9 1                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------|----------------------------|---------------------------|-----------------------|------------------------|
| 353057                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1 -           | FOR 404 Decatur                                            |                                                                                      |                | ALTH AND MENTAL HYG        | IENE O J                  | 0 4.                  | 4                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | REGISTRAR Cumberla                                         |                                                                                      |                | ATE OF DEATH               | REG. N                    |                       |                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | CEASED NAME FIRST OR PRINT)                                | WIDDLE                                                                               | LAS            |                            | 2a. DATE OF DEATH         | MONTH DAY YEAR        | 2b. HOUR               |
| by be<br>bage 3<br>death                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |               | Jennie                                                     | Josephine                                                                            | Wils           | on                         | December 1                | 1. 1985               | 10-50PM                |
| Do De de                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 3. SE         |                                                            | 4 RACE                                                                               | 5. DATE OF     |                            | 6. AGE (IN YEARS LAST BIR | MONIHS DA             | AR IF UNDER 24 HRS     |
| s of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 1             | FEMALE                                                     | WHITE                                                                                | SEPT .         | 7 1930                     | 55                        | YRS.                  | TOURS MINE             |
| Pog dir                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |               | RTHPLACE (STATE OR FOREIGN                                 | 76. CITIZEN OF WHAT COUNTRY                                                          | 2 8            |                            |                           | R COUNTY OF DEATH     |                        |
| eoth.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ,             | MARYT AND                                                  | USA                                                                                  | WIDOWED        | NEVER MARRIED DIVORCED     | Allegany                  | County,               | MD.                    |
| with the fo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 10, C         | TY OR TOWN OF DEATH                                        | <ol> <li>NAME OF HOSPITAL, NURS<br/>(IF NOT IN SUCH FACILITY, GIVE STREET</li> </ol> |                | OTHER INSTITUTION          | 12a USUAL OCCUPATI        |                       | D OF BUSINESS OR<br>RY |
| is of the difference of the di |               | CLIMBERT AND                                               | Sacred Heart                                                                         |                | al                         | McCROYS DEL               | T STORE C             | LFRK                   |
| s have ed in dbe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | USU/          | TATE 13b. COUN                                             | OTHER INSTITUTION, GIVE RESIDENCE BEFORM  13c. CITY OR TO                            | ORE ADMISSION) | 34 INSIDE CITY LIMITS?     | 13e.STREET ADDRESS        | ZIP CODE              | 21502                  |
| AND 124                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | MAF           | RYLAND ALLEG                                               | ANY CUMBERLA                                                                         | AND            | YES NO [                   | 537 FAIRVII               | W AVE CLIME           | FRIAND MD              |
| BALTIMORE, MARYLAND 2120  BALTIMORE, MARYLAND 2120  Wegen to completely filled in by open to ord completely filled in by ord control ord c | 14 FA         | THER'S NAME                                                | AIDDLE LAST                                                                          | 1              | 5. MOTHER'S MAIDEN NA      | ME                        |                       | IAST                   |
| mple and war                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |               | JOHN PULLEM                                                | Eleganicale                                                                          |                | MANDA                      |                           | (INK)                 |                        |
| E C C C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |               | VAS DECEASED EVER IN U.S. ARA                              | MED FORCES? 166 SOCIAL SEC                                                           | URITY NO.      | 7 INFORMANT                | ADDR                      | SS                    |                        |
| Pog e                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |               | NO                                                         | 215267                                                                               | 110            | VILLIAM WILSO              | ON 537 FAIR               | JIEW AVE CU           | MBERLAND M             |
| The the the the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | 18 CAUSE OF DEATH (Enter and                               | y ane cause per line for (a), (b), o                                                 |                | 1. 11                      |                           | APPI<br>BETWE         | ROXIMATE INTERVAL      |
| T, go                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |               |                                                            | E CAUSE (O)                                                                          | 410 En         | Octorso Aden               | OCAKCINONA OF             | PANKREAS              |                        |
| Z B B B B B B B B B B B B B B B B B B B                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |               | WW.CDW.                                                    | DUE TO, OR AS A CONSEO                                                               | LIENCE OF      |                            |                           | N. R. E. G. N         |                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | Canditians, if any, which                                  | DUE 10, OR AS A CONSEC                                                               | OLINCE OF      |                            |                           | S. American           |                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               | gave rise to immediate cause (o), stating the              | ) 10)                                                                                |                |                            |                           |                       |                        |
| 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |               | underlying couse lost.                                     | DUE TO, OR AS A CONSEO                                                               | UENCE OF       |                            |                           |                       |                        |
| 201<br>0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |               | PART 2 OTHER SIGNIFICANT C                                 | ONDITIONS CONTRIBUTING TO                                                            | DEATH BUT N    | OT RELATED TO THE TERM     | INAL DISEASE OR CON       | DITION GIVEN IN PART  | lia                    |
| DS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Z             |                                                            |                                                                                      |                |                            |                           |                       |                        |
| DIVISION OF VITAL RECORD NG PHYSICIAN. The law requestion otherwise physician of the this contribute from the the ball distribute permit. The his and Membil Hygene prior to anked as them 18 appears any mill                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | CERTIFICATION | 19a DATE OF OPERATION                                      | 196. CONDITION FOR WHIC                                                              | HOPERATION     | WAS PERFORMED              | 20s AUTOPSY?              | 206. IF YES, WERE FIN | IDINGS USED            |
| The poor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ¥             |                                                            | and the state of                                                                     |                |                            | YES TO NOTE               | IN CERTIFYING CAUS    | SES OF DEATH?          |
| A 10 410 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 100           | 210. ACCIDENT WAS UNDERLYING                               | 216. TIME OF INJURY                                                                  | T              | 21c HOW INJURY OCCUR       |                           |                       | 2)                     |
| 4 4 4 4 4 4 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10760         | OR CONTRIBUTING CAUSE OF DEA                               |                                                                                      |                |                            |                           |                       |                        |
| NO STORY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | MEDICAL       | (IF EITHER NOTIFY MEDICAL EXAMINER)                        | P.M.<br>21e PLACE OF INJURY                                                          | 19             | 211. LOCATION              |                           |                       |                        |
| ASIA THE PERSON OF THE PERSON  | F.            | WHILE NOT WHILE T                                          | (AT HOME STREET, FACTORY, OFFICE                                                     | E, FARM, ETC ) | STREET                     | CITY OR TO                | MM CONILA             | STATE                  |
| DING OIL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |               | 22a.1 certify that (1) (this haspit                        | all attended the deceased from                                                       |                | . 19                       | to                        | . 19                  | _, that (I) (we) last  |
| N = 0 2 7 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |               | saw the deceosed alive on<br>abave, (1) (we) (did) (did so |                                                                                      |                | that in (my) (our) opinian |                           |                       |                        |
| A d d d d d d d d d d d d d d d d d d d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |               | abave, (1) (we) (did) (did not                             | view the bady after death.                                                           | DI             | GREE                       |                           | 127c D/               | ATE SIGNED             |
| 80 t d d d d d d d d d d d d d d d d d d                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |               | M                                                          | U asone 1                                                                            | m              | ATTENDING                  | MEDICAL STA               | FF _ IO               | -12-85                 |
| A State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |               | THE PHYSICIANUS NAME (THE OF                               | EPHINE)                                                                              | 1,20           | 22e ADDRESS                | DIRECTOR LITTISIC         | IAN L                 | 0                      |
| HOS<br>Pund C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |               | Constant                                                   |                                                                                      |                | 925 Bishop                 | Walsh Road,               | Cumberland            | . MD 21502             |
| 58 5813                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 230           | Gary Wagonet<br>BURIAL, CREMATION, REMOVAL                 |                                                                                      | NAME OF CE     | METERY OR CREMATORY        | 234 LOCATION              |                       | V                      |
| 90                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |               | SPECIFY) BURIAL                                            |                                                                                      |                | P VETERANS C               | CITY OF TOWN              | ONTE ATTECAN          | STATE STATE            |
| DP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 24 F          | UNERAL DIRECTOR                                            | F-1 10 1005 II                                                                       | OOKI ON        | 25                         | ENT PROPERTY              | UNE ALLEGAN           |                        |
| DHMH - 16 50M 4/83<br>(VRA 15, 4)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |               | NAME                                                       | ADDRESS                                                                              | OT BADDEO      | TO MADE THE                | PIN O MED.                | relia Devidour        | Bindelle               |
| (VKM 13, 4)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 0.            | LCOX-MERRITT FU                                            | INEKAL SEKVICE (                                                                     | COMBEKT        | AND MARYLAND               | 0                         |                       |                        |

Podoline Himsel. confid enistrant nimet LDecember 115 1985 - 10.50cm Admind yrape.Lit. figure of the contract GIFTASATE

925 Rigido Daleh Ross, Carlamiland, 15: 21502 

BANK LEED ALL BANK BANKS

FOR - STATE

### STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH REG. NO. LA5T 20 DATE OF DEATH MONTH YEAR 2b HOUR WILSON DECEMBER 7, 1985 5 DATE OF BIRTH 6 AGE (IN YEARS LAST BIRTHDAY)

DECEASED NAME EIRST TYPE OR PRINT VIRGINIA RETA 4 RACE 3 SEX 28 DAY 1901 FEMALE WHITE 9 BALTIMORE CITY OR COUNTY OF DEATH 7a. BIRTHPLACE ISTATE OR FOREIGN 76 CITIZEN OF WHAT COUNTRY? MARRIED XX NEVER MARRIED COUNTRY ALLEGANY COUNTY W. VA WIDOWED IN CITY OR TOWN OF DEATH NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 12a USUAL OCCUPATION LITYPE OF WORK FOR MOST OF WORKING LIFE SACRED HEART HOSPITAL CUMBERT AND HOUSEWIFE JOUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 136 COUNTY 13c CITY OR TOWN 136 INSIDE CITY LIMITS? 13e STREET ADDRESS / ZIP CODE VALLEY ROAD MARYLAND NO T AT J.F.GANY TIMBERTAND 14 FATHER'S NAME MIDDLE VIRGINIA CARTWRIGHT MILLARD BARTLETT ADDRESS 160 WAS DECEASED EVER IN U.S. ARMED FORCES 17 INFORMANT 166 SOCIAL SECURITY NO IYES NO OR UNKNOWN LIF YES, GIVE WAR OR DATEST 217-54-6295 OSCAR WILSON RFD# 3 VALLEY ROAD CUMBERLAND 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and ics. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Recent Canditians, if any, which gave rise to immediate cause (a), stoting the DUE TO, OR AS A CONSEQUENCE OF underlying cause PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110 196 CONDITION FOR WHICH OPERATION WAS PERFORMED 20b. IF YES, WERE FINDINGS USED 20a AUTOPSY? IN CERTIFYING CAUSES OF DEATH? 71n ACCIDENT WAS UNDERLYING 216. TIME OF INJURY 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) HOUR A.M. MONTH DAY YEAR OR CONTRIBUTING CAUSE OF DEATH LIE EITHER NOTIFY MEDICAL EXAMINER 211 LOCATION 21d INTURY OCCURRED 21e PLACE OF INILIRY CITY OR TOWN (AT HOME STREET FACTORY, OFFICE, FARM ETC.) NOT WHILE 22a. | certify that (1) (this haspital) attended the deceased from, saw the deceased olive an\_ \_, and that in (my) (our) opinian death occurred on the dote and hour and from the causes stated obove, (1) (we) (did) (did nat) view the bady after death 22b. SIGNATUR DEGREE ATTENDING Y MEDICAL PHYSICIAN DIRECTOR PHYSICIAN

ld be del the State

DHMH - 16 60M 7/84 (VRA 15, 4)

23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL

V. EUGENE MAZZOCCO

23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK

22e ADDRESS

CUMBERLAND, MD

BMG, 912 SETON DRIVE

CUMBERLAND ALLEGANY MARYLAND

24 FUNERAL DIRECTOR

HOME CUMBERLAND MARYLAND

250 DATE REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATURE

COUNTY

STATE

12b. KIND OF BUSINESS OR

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

24

SCHOOL TEACHE

RETA VILGIDIA VILEGI

SECT (C) DESPENDED

SOI:E

SACRED HEART HISTOTAL

V. EUGBE NATIONSON

DIG, 912 SETON DRIVE CURBERLAND, NO 21302

UEC 33 Ette Julia transmir Thistories

BP.

DHMH - 16 60M 7/84

(VRA 15, 4)

361021

FOR STATE REGISTRAR

# STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

|   |               | OR PRINT)                         | FIRST           |                   | WIDDLE              | ,               | W21                          | 20. DA      | ALE OF DEATH MONTH                          | 1 DAY YEAR             | 26. HOUR           |
|---|---------------|-----------------------------------|-----------------|-------------------|---------------------|-----------------|------------------------------|-------------|---------------------------------------------|------------------------|--------------------|
|   |               |                                   | _ JOHN          |                   | DANIEL              | W               | INTERS                       |             | CEMBER 19,                                  | 1985                   | 10:00A.            |
| / | 3 SEX         | (                                 |                 | 4 RACE            |                     | S. DATE C       |                              | 6 AGE       | (IN YEARS LAST BIRTHDAY)                    | IF UNDER I YEAR        | HOURS MIN.         |
|   | Ma            | le                                |                 | White             |                     |                 | ary 31.1927                  |             | 58 Y                                        | rrs Dars               | HOURS MIN.         |
|   | 7a BIF        | RTHPLACE (STATE C                 | OR FOREIGN      | 76 CITIZEN OF     | WHAT COUNTR         | Y? 8            | XX NEVER MARRIED             | 9 BAL       | TIMORE CITY OR COL                          |                        |                    |
| 0 |               | arvland                           |                 | IISA              |                     | WIDOWE          |                              |             | ALlegany                                    |                        | MD.                |
| N | 10 CT         | TY OR TOWN OF D                   | EATH            |                   | HOSPITAL, NURS      |                 | OR OTHER INSTITUTION         | 12a US      | SUAL OCCUPATION<br>OF WORK FOR MOST OF WORK | 12b. KIND C            | OF BUSINESS OR     |
| 7 | CUM           | BERLAND                           |                 |                   | AL HOSPI            |                 |                              |             | lly-SPringf                                 |                        | Company            |
| 1 | USUA          | AL RESIDENCE (IF NE               | IRSING HOME OR  | OTHER INSTITUTION |                     | ORE ADMISSION)  | 13d INSIDE CITY LIMITS?      |             |                                             |                        |                    |
| 9 |               | aryland                           |                 | egany             | Cresap              |                 | YESXX NO                     | 136         | REET ADDRESS / ZIP C                        | e Lane /               | 21502              |
| 1 |               | THER'S NAME                       |                 | WIDDLE            | 1467                |                 | 15 MOTHER'S MAIDEN           |             |                                             |                        |                    |
|   |               | Osbey                             |                 | - MIDDLE          | Winte               | rs              | Mae                          |             | WIDDLE                                      | Phil                   | lips               |
|   |               | VAS DECEASED EVE                  |                 |                   | 166 SOCIAL SE       |                 | 17 INFORMANT                 |             | ADDRESS                                     |                        | 11/1/2             |
| 7 | (Y            | YES. NO OR UNKNOWN)               |                 | W. II             | 216-22-             | 6754            | Merle L. Wi                  | inters      | -Address s                                  | ame as #1              | 3 ahove            |
|   |               | 18 CAUSE OF DEA                   |                 |                   |                     |                 | THEFT E. HI                  | THOCH       | , madress s                                 |                        | ONSET AND DEATH    |
|   |               | PART I. DEATH                     | WAS CAUSE       | D BY:             |                     |                 | RATORY                       | ARRE        | ×7                                          | BETWEEN                | ONSET AND DEATH    |
|   | 13            | STELLED!                          | MMEDIAI         | E CAUSE (o)       |                     |                 | -0                           | //          | 7.                                          |                        |                    |
|   |               | Conditions, if or                 | w which         | DUE TO, O         | PILAZOA             |                 | EMBOLL                       | SU          |                                             |                        |                    |
|   |               | gove rise to in                   | mmediote        | (6)               | /                   | /               |                              |             |                                             |                        |                    |
|   |               | couse (o), sto-<br>underlying cou |                 | DUE TO, O         | PILL MO             | WATEL           | INFARCT                      | TION        |                                             |                        |                    |
|   |               | PART 2 OTHER SIG                  | GNIFICANTO      | ONDITIONS CO      |                     |                 | NOT RELATED TO THE TE        |             | ISEASE OR CONDITION                         | N GIVEN IN PART 1      |                    |
|   | Z             | DER                               |                 | 471NG             |                     |                 | ILCER                        | ERMINALD    | ISEASE OR CONDITION                         | V CIVELY IN TAKE IS    | o .                |
| 7 | AT            | 19a DATE OF OPER                  |                 |                   |                     | CH OPERATIO     | N WAS PERFORMED              | 20o         |                                             | IF YES, WERE FINDI     |                    |
| / | CERTIFICATION | 1000                              |                 |                   |                     |                 |                              | YES         | NO INC                                      | CERTIFYING CAUSES      | NO [               |
| 1 | GE            | 21a ACCIDENT WAS U                | h-a             | 216. TIME O       |                     | DAY VEAD        | 21c. HOW INJURY OCC          | URRED (E    | NTER NATURE OF INJURY IN ITE                | M 18 PART I OR PART 2) |                    |
|   | ¥.            | OR CONTRIBUTING                   | -               |                   | M. MONTH<br>M.      | DAY YEAR        |                              |             |                                             |                        |                    |
|   | MEDICAL       | 21d INJURY OCCU                   |                 | 21e PLACE         | OF INJURY           |                 | 211. LOCATION                |             | CITY OR IOWN                                | COUNTY                 | STATE              |
|   | Σ             | WHILE NOT                         | WHILE           | (AT HOME STE      | REET FACTORY, OFFIC | E, FARM ETC )   | ZIMEET                       |             | CITY ORTOWN                                 | 0001411                | STATE              |
|   | 1             | 27c.1 certify those               | (I) (this bount | tul) ottended th  | e deceased from     | 11-2            | F 19 > i                     | - , to      | 12-19                                       | 19 55                  | that (I) (we) lost |
|   | /             | sow the decre                     | and of or on    | 11-11             | offer death         | <u>\$5</u> , or | nd that in (my) (our) opinio | ion deoth o | ccurred on the date and                     |                        |                    |
|   |               | 77h SIGNATURE                     | 1               | 4 .               | Mile Seattle        |                 | DEGREE                       | The last    |                                             | 22c DATE               | SIGNED             |
|   |               | 01                                | ATTO            | erre              | 1                   |                 | ATTENDING PHYSICIAN          | G MED       | CTOR PHYSICIAN                              | 7 /2/                  | 19/85              |
| 1 | 1             | 274 PHYSHIAN S                    | YAM TIVE        | e receil)         |                     |                 | MEMORIAL H                   | HOSPIT      | TAL MEDIC                                   | AL BUILVI              | NG                 |
|   | 6             | DR. TORR                          | ES              |                   |                     |                 | CUMBERLAND                   | D, MAH      | RYLAND                                      | 21502                  |                    |
|   | 23a. B        | URIAL, CREMATION                  | N, REMOVA       | 23b. DATE         | 23                  | c. NAME OF C    | EMETERY OR CREMATOR          | RY 23d.     | LOCATION                                    |                        |                    |
|   | Bi            | urial                             | -               | 12-21-            | -85 H               | lillcre         | st Burial Pa                 | ark CI      | umberland-A                                 | llegany C              | o.,-Md.            |
|   |               | JNERAL DIRECTOR                   | George          | -Upchure          | ch Funer            | al Hom          | e. P.A. 250 D                |             | D. BY REGISTRAR 256. RE                     | EGISTRAR'S SIGNAT      | TURE               |
|   |               | 02 Greene                         |                 |                   |                     |                 |                              | DEC         | 24 1985                                     | wheredo                | n-Abridate         |
|   | `             | ~. 66:16                          | 70166           | - COMME           |                     |                 |                              |             |                                             |                        |                    |

| 1    | FOR<br>- STATE                                   |                                                                         |                                     |                                  | NT OF HEAL               |                 | MENTAL H             | YGIENE       | . 5                               | 3            | 2                 | 3 .                        | 1 ;          |
|------|--------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------|----------------------------------|--------------------------|-----------------|----------------------|--------------|-----------------------------------|--------------|-------------------|----------------------------|--------------|
| 5    | REGISTRAR                                        | r FIRST                                                                 | WE                                  | MIDDLE                           | AMINER'S                 | CERTIFI         | CATEO                | PF DEAT      | Н                                 | REG. NO.     |                   |                            |              |
|      | DECEASED NAM                                     |                                                                         |                                     |                                  | X17 7                    | C . I           |                      |              |                                   | XX ITS       | MONTH             |                            | 26. HOUR     |
| _    | CEV.                                             | Mar<br>14 RACE                                                          | JS. DATE OF BIRTH                   | lice                             | WOL<br>AGE (IN YEARS) IF | ford            | IF UNDER             |              | DEATH MA                          | ATED         | MONTH             | 20198                      | FEAR 2d HOUR |
| 3. 3 | Female                                           |                                                                         | Jan 21,                             | 1898                             |                          | NTHS DAYS       | HOURS                |              | DATE<br>ONOUNCE<br>DEAD           | D            | 12                | 20 198                     | 12:20        |
| 310  | BIRTHPLACE (S<br>FOREIGN COUNTRY)                |                                                                         | 76. CITIZEN OF W                    |                                  | MA                       | RRIED NI        | EVER MARRI           | IED 📙        | Alle                              | _            | _                 | TY OF DEAT                 |              |
| 7    | CITY OR TOWN                                     |                                                                         | 11. NAME OF HO                      | SPITAL, NURSI                    | NG HOME, OR C            | THER INSTITU    | UTION                |              | LOCCUPAT<br>STOF WORKING<br>Memak | ION (TYPE    |                   | 12b. KIND O<br>OR IND      | F BUSINESS   |
|      | DAL RESIDENCE<br>STATE<br>W. Va                  | 13h COUN                                                                | OR OTHER INSTITUTION, G             |                                  | ORE ADMISSION)           |                 | (ITY LIMITS?         | "500         | TADDRESS                          | kado         | on L              | ane                        | 199          |
| -    | FATHER'S NAM                                     |                                                                         | MIDDLE                              | McKen                            | zie                      | 15 MOTH         | HER'S MAIDE<br>Argar | et NAME      | Ann                               | E            | Fl                | eek                        |              |
| 160  |                                                  | D EVER IN U.S. AR                                                       | MED FORCES?<br>WAR OR GATES)        |                                  | L SECURITY NO.           | 17. INFOR       | THAMS                |              |                                   | DDRESS       |                   | Chan                       | Texas        |
|      | Candition gove in                                | ons, if any, which<br>ise to immediate<br>i) stating the <u>under</u> - | TE CAUSE (o) DUE TO, OI             | R AS A CONSE                     | rteriosc                 |                 |                      | rt dis       | ease                              |              |                   |                            |              |
|      |                                                  | IGNIFICANT CONDITIONS                                                   | CONTRIBUTING TO DEATH               | BUT NOT RELATED                  | TO THE TERMINAL DIS      | EASE OR CONDITI | ION GIVEN IN PA      | RT 1 (e).    |                                   |              |                   |                            |              |
| 7    | 190. DATE O                                      | FOPERATION                                                              | 196. COND                           | TION FOR WH                      | IICH OPERATION           | WAS PERFO       | DRMED?               |              |                                   |              |                   | 20 AUTO                    |              |
|      |                                                  | AL CAUSE WAS GOR ING CAUSE OF                                           |                                     | A. MONTH D                       |                          | HOW INJUR       | RY OCCURRE           | D LENTER NAT | TURE OF INJURY                    | IN ITEM 18 P | ART 1 OR PA       | _                          | -2.20        |
|      | CONTRIBUT<br>21d INJURY<br>WHILE<br>AT WORK      | OCCURRÉD<br>NOT WHILE [<br>AT WORK                                      |                                     | OF INJURY (<br>TORY, FARM, ETC.) |                          | STREET          |                      | C            | CITY OR TOWN                      |              | co                | VINU                       | STATE        |
|      | 220   cert<br>death resul<br>ACTUAL<br>SIGNATURE | ted fram: Natu                                                          | ge of the remains de<br>tral causes | Accident C                       | held an Au  Suicide      | TITLE (         | Inspection (SPECIFY) | Undeterr     | Inquiry Inquiry Inquired monned   | er [],       | DATE<br>SIGNE     | pinion<br>ED <u>12–2</u> ( | 0-85         |
| 73   | EXAMINER'S<br>(TYPE OR PR                        | INT)G10V                                                                | anni Mast                           |                                  | M.D.                     |                 |                      | 23d. LOC     | ATION                             | Cum          |                   |                            | MD 21502     |
|      | (SPECIFY) BU                                     | ctor                                                                    | 23 Dec                              | 85 Que                           | ens Po                   |                 |                      | REC D. BYR   | TOWN                              | 25ho REGIS   | Mine<br>STRAR'S S | ral i                      | W. Va.       |
|      | Al                                               | Len Rot                                                                 | ruck Ke                             | yser,                            | W.Va.                    |                 | LUEL                 | 4.0 k        | 00                                | June         | - Incorporate     |                            |              |

Cumberlend Secret Heart Hospital Honesakar --

w. va. Mineral Advect x 500 Carefugon Lene

Ve 8897 is day of ide blame's

Allen Actrack Reyacr, w. Vs.

Siries 23 and Danders Foint Mayor winerol W. Va.

reinnaffi kon t th brollon frau Tesos di des

| 340132                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | /                                                                                                                                                                 | FOR Mair REGISTRAR Lona CEASED NAME                                                                                                                                                   | n Sta                                                 |                                                                                             |                                               | CEDTIE                       | EALTH AND                                   | MENTAL HYG<br>DEATH |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | G. NO.         | A VEAR          | 7                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------|------------------------------|---------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------|---------------------------------------------|
| t moy be<br>r poge 3<br>trer deoth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 3. ,SE                                                                                                                                                            | OR PRINT)                                                                                                                                                                             | Hele                                                  | RACE                                                                                        | Cecelia                                       |                              | Woods 5. DATE OF BIRTH                      |                     | 1.2 .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | -01-85         | IF UNDER 1 YEAR | 2b HOUR  8:574  IF UNDER 24 HRS HOURS I MIN |
| orth. Poge 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                   | emale<br>RTHRMS (STATE OR FOR                                                                                                                                                         | reign 7                                               |                                                                                             | Lte<br>WHAT COUNTRY                           | MARRIEI                      | Sept. 17, 1918  MARRIED   NEVER MARRIED   S |                     | 9 BALTIMORE CITY OR COUNTY OF DEATH allegany county                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                |                 |                                             |
| ter dec                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | u city or town of Death Cumber Land                                                                                                                               |                                                                                                                                                                                       |                                                       | 1. NAME OF<br>(IF NOT IN SU                                                                 | HOSPITAL, NURSI CHEACILITY, GIVE STREE Sacred | ADDRESS)                     | R OTHER INS                                 |                     | 12d USUAL OCCUPATION 12b, KIND OF BUSINESS OR INDUSTRIBOTH INDUSTRIBOT |                |                 |                                             |
| LAND 212                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Md                                                                                                                                                                |                                                                                                                                                                                       | HOME OR O                                             |                                                                                             |                                               | E ADMISSION)                 | ing 13d INSIDE CITY LIMITS?                 |                     | 136 STREET ADDRESS / ZIP CODE<br>2 St. Marys Te                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | 2/539<br>errace |                                             |
| Daniel Company                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Terence Towns Woods LAST France's Malden NAME France's Grime's'  160 WAS DECEASED EVER IN U.S. ARMED FORCES? 160 SOCIAL SECURITY NO. 17 INFORMANT ADDRESS CUMBERS |                                                                                                                                                                                       |                                                       |                                                                                             |                                               |                              |                                             |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                |                 | 13027                                       |
| BALTIMORE,  f  cote be executed by scion and experts. Pages  two!.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                   |                                                                                                                                                                                       | ED FORCES?<br>WAR OR DATES)                           |                                                                                             |                                               |                              |                                             |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                | Md              |                                             |
| DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BAING PHYSICIAN: The law requires that the death certificate of the actificate has been signed by the ottending physic os the buriol-transit permit. Then please remove carbon paper to and Mental Hygiene prior to buriol, cremation, or removal orked or them 18 shaws ony injury, or other traumottic event, the content of the prior of the | NO                                                                                                                                                                | PART I. DEATH WAS  IM  Conditions, if ony, w gove rise to immed couse (o), stoling                                                                                                    | S CAUSED<br>AMEDIATE<br>which<br>diole<br>the<br>lost | DUE TO, C                                                                                   | DUE TO, OR AS A CONSEQUENCE OF MAN            |                              |                                             |                     | roundeder many                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                |                 | mutos<br>my m                               |
| TALRECO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | CERTIFICATION                                                                                                                                                     | 19a DATE OF OPERATIO                                                                                                                                                                  |                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  21b. TIME OF INJURY  21c. HOW INJURY OCCU |                                               |                              |                                             |                     | 200 AUTOPSY?  200 IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  YES NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                |                 |                                             |
| UVISION OF VI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | MEDICAL C                                                                                                                                                         | OR CONTRIBUTING CALL TIFEITHER NOTIFY MEDICAL  21d. INJURY OCCURRED WHILE AT WORK AT WORK                                                                                             | JSE OF DEATH<br>EXAMINER)                             | HOUR A                                                                                      |                                               | AY YEAR<br>19<br>FARM, ETC ) | 211 LOCATK                                  | NC                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OR TOWN        | COUNTY          | STATE                                       |
| ArTENDIN<br>ospitol or<br>ECTOR. At<br>d for use of<br>it. of Health<br>m 21 is mo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                   | 220.1 certify that (1) (this hospital) attended the deceased from 19, 10, 19, that (1) (we) lost sow the deceased alive an obove, (1) (we) (did) (did not) view the body after death. |                                                       |                                                                                             |                                               |                              |                                             |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                |                 |                                             |
| SPITAL OR 13 by the hole he detoche e Stote Dep                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                   | 22d PHYSICIAN'S NAM                                                                                                                                                                   | TUN PRINT)                                            | PHYSIC                                                                                      |                                               |                              |                                             |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                |                 |                                             |
| TO HOSPITA retoined by TO FUNERA should be de should be de IMPORTAIT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 73a B                                                                                                                                                             | Donald Manger, M.D.  55 Jackson Street, Lonaconing Burial CREMATION, REMOVAL 238. DATE 1985 Sunset Mem. Park Cumber and Alberany  21 Cumber and Albertany                             |                                                       |                                                                                             |                                               |                              |                                             |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                |                 |                                             |
| BP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (                                                                                                                                                                 | SPECIFBUTIAL                                                                                                                                                                          | MOVAL                                                 | Sec.4                                                                                       | ,1985 Si                                      | inset                        | Mem.                                        |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                |                 |                                             |
| DHMH - 16 60M 7/84<br>(VRA 15, 4)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Ë                                                                                                                                                                 | ichhorn F                                                                                                                                                                             | uner                                                  | al Ho                                                                                       | me, Lona                                      | conin                        | g,Md.                                       | 250                 | C'D. BARE 1989                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ON 250 REGISTR | AK S SIGNATU    | IKE                                         |

Property Strongs Some Logarda Wist SCIOPE Consocing or 21520 The Consocing Melen Cecilia Foods arer - Jan -- ban Prospil Consumer Con Inditional Beart Mongath The state of the second of the . In . To be a second of the s